Integrative Health Partners
Linda Dagenais, N.D.
5600 Kirkwood Pl N. Ste. A, Seattle WA 98103 • Tel: 206-903-6111 • Fax 206-903-6125 • www.IntegrativeHealthPartners.com

For Office Use Only

NAME:	DATE OF BIRTH:	SEX:	DATE:

Patient Information

Thank you for choosing our office! In order to serve you properly, we ask that you fill out the following information. All information will be confidential and if you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help. Please submit an electronic copy or fax it to our office. A signed hard copy will be needed when you arrive for your first appointment.

Patient's Name _____ *Date of Birth* _____ *Date of Service* _____

☐ **Male** ☐**Female**

If Minor: Guardian's name _____ *Relationship to patient* _____

Home Phone _____ *Cell Phone* _____ *Work Phone* _____ *Number easiest to contact* _____

a) *For texting reminders of your upcoming appointments, who is your cellular provider:* ☐AT&T ☐Verizon ☐T-mobile ☐Other: _
b) *HIPAA regulations require permission to leave detailed messages. Is it ok to leave this kind of patient and/or billing information? May we leave confidential messages?* ☐**Yes** ☐**No**

Address _____ *City* _____ *State* _____ *Zip* _____

Email _____ *Marital Status* _____ *Name of spouse or partner* _____

May we send medical insurance bills to this email ☐**Yes** ☐ **No** *(Partner, Married, Single Divorced, Separated, Widowed)*

Patient or guardian's employer and location _____ *Occupation* _____

If student, name of school and location _____ *Whom may we thank for referring you?* _____

Person to contact in an emergency _____ *Phone* _____ *Relationship to patient* _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ *Home Phone* _____ *Relationship* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Driver's license #: _____ *Date of Birth* _____ *Financial Institution* _____

Is this person currently a patient of our office
No ☐ **Yes** ☐

Employer _____ *Work Phone* _____

INSURANCE INFORMATION:

Insured's name _____ *Date of birth* _____ *Relation to patient* _____

Insurance Company _____ *ID #* _____ *Group ID#* _____ *Insurance Phone #* _____

$ _____ *What is your deductible?* $ _____ *How much have you used?* $ _____ *Copay* _____ *If you have additional insurance, which one?*

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.

Signature of patient or guardian (if minor)-*To be signed in office* _____ Date _____

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Patient Financial Agreement

Naturopathic First Office Call: $290

- This fee is charged for the first time a client is seen at Integrative Health Partners.
- This is an extended visit; allow approximately 1½ hours.

Naturopathic Return Office Call: $200

- Allow approximately 1 hour for this visit.

Phone Consultation: $45 minimum charge

- This fee is charged for any phone consultation requiring 15 minutes or less.
- If it extends beyond 15 minutes there will be a greater charge.
- The cost varies dependent upon time spent and complexity.
- If there are any questions about this service, please ask at the time of the call.
- Please be aware that insurance does not cover phone consultation.

Cancellation Charge:

- No charge if cancelled with a minimum of 24 hour notice.
- There is a **$35** fee with less than 24 hour notice.
- **Full fee** will be charged if no notice is received.

Payment:

- Payment for visit and/or medication and supplies is to be rendered at time of service and can be made by cash, check, money order, Visa or Mastercard. Copays will be charged/collected by our billing service
- If medications are mailed to you, a postage and handling fee will be added to the cost. Payments can be made by check, Visa or Mastercard.
- There is a minimum billing fee of 12% APR, whichever is greater, for account balances due beyond 30 days.
- There is a $35 NSF fee on all returned checks.
- Patients will be held responsible for non-payment by their insurance company. Accounts unpaid by the insurance company greater than 90 days will be billed to the patient.
- Outstanding balances greater than 120 days will be turned over to a collection agency unless prior arrangements have been made in writing.

Integrative Health Partners is committed to providing quality care for the whole family. Our Doctors appreciate your patronage.

IF I HAVE INSURANCE, I UNDERSTAND THAT I AM RESONSIBLE TO READ MY MEDICAL BENEFIT BOOK AND UNDERSTAND IT. WHEN APPLICABE, I AM RESPONSIBLE TO PAY A PERCENTAGE OF THE COST OF MY VISIT AT THE TIME OF TREATMENT. I AGREE THAT I AM FULLY RESPONSIBLE FOR THE TOTAL PAYMENT OF ALL PROCEDURES PERFORMED IN THIS OFFICE. THIS INCLUDES ANY TREATMENT THAT IS NOT A BENEFIT OF ANY MEDICAL INSURANCE THAT I MAY HAVE

I, _____ agree to the above defined financial policies of Integrative Health Partners. In the case of default of payment, I am responsible for full payment of the balance, interest accrued, and any collection costs and legal fees incurred to collect on this account.

I, the undersigned, have read, understand, and accept the information and conditions specified in this document.

Patient signature- *To be signed in office*	Print name	Date

INFORMED CONSENT FOR TREATMENT

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I, _____, hereby authorize Linda Dagenais, ND to perform procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g. venipuncture, laboratory, Pap smears, or radiography**.**

- **Minor office procedures:** e.g. dressing a wound, ear lavage, skin tag or wart removal.
- **Medicinal use of nutrition:** therapeutic nutrition, diet therapy, nutritional supplementation, and nutrient and/or vitamin injections.
- **Botanical medicine:** botanical substances may be prescribed as teas, tinctures, capsules, tablets, creams, ointments, plasters, or suppositories.
- **Lifestyle counseling and hygiene:** promotion of wellness including recommendations for diet, exercise, sleep, stress reduction and balancing of work and social activities.
- **Psychological Counseling**

Linda Dagenais, ND does not make recommendations for medical treatments or pharmaceuticals or for the discontinuation of other treatments and/or procedures with other health care professionals that are not within her scope of practice. Patients that require such treatments will be referred appropriately.

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

- **Potential Risks:** allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures. Additional information on side effects and complications is available upon request.

- **Potential Benefits**: restoration of health and the body's maximum functional capacity without the use of drugs or surgery, 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, as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Linda Dagenais, ND 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.

_____ _____

Signature of Patient-*To be signed in office* Date

_____

Signature of Patient Representative or Guardian

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

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AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on *(insert date)* and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, *(insert name)*. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

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Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $ *(insert fee)* for each page and the staff time charged will be $ *(insert fee)* per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: Integrative Health Partners

Privacy Officer: Linda Dagenais, ND,

Telephone: 206-903-6111 Fax: 206-903-6125

E-Mail: contactus@IntegrativeHealthPartners.com

Address: 5600 Kirkwood Pl. N, Ste. A, Seattle WA 98103

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

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NAME:	DATE OF BIRTH:	SEX:	DATE:

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Please print your name here

_____
Signature-*To be signed in office*

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____ _____

Employee signature **Date**