Dr. Amy Wells
5470 Shilshole Ave NW #300
Seattle, WA 98107
206-632-2154

Patient Information Form

Last Name:________________________________ First Name:__________________ M.I. ____ Date of Birth:_________________________

Other names/nicknames your records may be kept under:_______________________________Relationship Status: _____________________

Address:____ Apt #/Addr Line 2:______________________________

City: _________________________________ State: _____ Zip code:____________Country: ________ Gender: _______________________

Occupation: ____ Employer/School: ____

Preferred Contact Number: ☐ Cell ☐ Home ☐ Work Can we leave a confidential message on voicemail?: ☐Cell ☐ Home ☐ Work

Text message okay?: Yes No Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to specify

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Decline to specify

Cell Phone: (___)_______________ Home Phone: (___)_______________ Work Phone:(___)______________________________

Social Security #: _____________________________________ Email: ____

Parent Name (minors only) ________________________ Parent Name (minors only) ____

Emergency Contact: _____________________________________ Contact's Phone #: (___)____

Are you hearing impaired? Y N Are you visually impaired? Y N Do you need an interpreter or TTY line? Y N

Do you have non-English language needs?: __________________________ (or) Special needs?: ___________________________________

How did you hear about us? ____

Insurance Information
Please notify us if processing Labor and Industry (L & I) or Personal Injury Protection (PIP) Claims
Please complete this section if we will be billing your insurance.

1. Does your insurance have alternative medicine benefits? Yes No

Who is your primary care provider (PCP)?:__________________________________ Phone #: (___)___________________________

Clinic address: _______________________________ City: ____________________ State: _____ Zip Code: _____________________

2. Primary Insurance Company & Plan Name: ____

ID Number: ____ Group/Policy Number: __________________________________

Name of policy holder: ___________________________________ Policy holder's date of birth: ____________________________

Relationship to policy holder: ______________________Is your primary a: (circle) POS PPO EPO HMO

3. Secondary Insurance Company & Plan Name: ____

ID Number: ____ Group/Policy Number: __________________________________

Name of policy holder: ___________________________________ Policy holder's date of birth: ____________________________

Relationship to policy holder: ____________________Is your secondary insurance a: (circle) POS PPO EPO HMO

I, the undersigned, pledge that the above information is accurate and complete to the best of my knowledge. I understand that payment is due at the time of service for all visits at the clinic unless prior arrangements have been made. I understand that if I am providing insurance billing information, I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize Dr. Amy Wells to release all information necessary to secure the payment of insurance benefits, and I authorize the use of this signature on all my insurance submissions.

X___________________________________ _________ X___________________________________ _______

Signature of patient* date Signature of guardian date

Relationship to patient: __________________________

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* Guardian's signature required for minors.

ADULT HEALTH HISTORY

THIS INFORMATION WILL BE CONTAINED IN YOUR CONFIDENTIAL MEDICAL RECORD

Last Name:___________________________________ First Name:____

Today's Date:___________________________ Birthdate:________________________ Gender:_______________

Please list in order of importance your chief concerns, main problem, or reasons for seeing the doctor:

1.
2.
3.
4.
5.

What goals do you have for your visit today?____

____

Date of last complete checkup:_____________________Diagnosis, if any:___________________________________

Please list prescription medications that you are currently taking, with dosages:

1.	2.	3.
4.	5.	6.

Please list vitamins, minerals, herbs, homeopathics or supplements that you are currently taking, with dosages:

1.	2.	3.
4.	5.	6.

Do you have any severe or life threatening allergies, sensitivities, or bad reactions to medications, foods, chemicals, animals or anything else? □YES □NO

If YES, please explain: ____

____

The general state of my health has been: □Excellent □Good □Fair □Poor

Height:___________ Weight:___________ Weight change in past 12 months: gain_____lbs loss_____lbs

Personal Habits

Do you follow any particular diet regimens or restrictions? If yes, please describe: _________________________

____

Caffeine: Coffee ___________cups per day Tea ___________cups per day

Smoking: Packs per day:_______ Number of years:________ Years stopped:_________ cigs/pipe/cigar/chew

Alcohol: What type?_________________________________ How much each week?__________________

Other: Soft drinks? Energy drinks? What type and how much per day? __________________________

Recreational drugs: What type? ______________________________ How often? ____________________________

Do you exercise regularly? □ YES □ NO If yes, what type? ____

How Long?_____________________________________ How Often? ____________________________________

How many hours do you sleep?____

Occupation:____

Past History

Hospitalizations: ____

____

Serious Illnesses and Injuries: ____

____

Family History

Please list family members with the following? □ Diabetes__________________ □ Heart Disease_________________
□ High Blood Pressure ___________________ □ Thyroid_____________________ □ Stroke ______________________
□ Cancer ________________ □ Alcoholism/Drug Addiction_________________ □ Mental Illness__________________

Any children? Yes No If yes, what are your children's names and ages? ___________________________________
____

System Review: Check if you currently have any symptoms or problems to any important or significant degree.

General:	***Gastrointestinal System:***	***Men's Issues:***
□ Weight loss/gain	□ Constipation	□ Prostate problems
□ Eating disorder	□ Diarrhea	□ Sexual difficulties
□ Appetite change	□ Blood in stool	□ Testicular pain/swelling
□ Tiredness, weakness	□ Hemorrhoids	□ Penis pain or discharge
□ Sudden energy drop, time of day	□ Nausea, vomiting	***Musculoskeletal System:***
□ Fever	□ Heartburn	□ Joint pain, swelling
□ Sweating at night	□ Indigestion	□ Pain in neck, shoulder, back, arm,
□ Sweating when tired	□ Abdominal pain/discomfort	hand, hip, buttock, leg, knee, ankle,
□ Bleeding tendency	□ Gas & bloating	foot (circle all that apply)
□ Bruise easily	□ Jaundice (yellowing of skin and eyes)	□ Cold hands or feet
□ Poor sleep	***Genitourinary System:***	□ Pins and needles sensation
□ Strong thirst (for hot or cold?)	□ Lower abdominal pain	***Cardiovascular System:***
□ Cravings	□ Kidney problem	DATE of last EKG:_____________________
E.E.N.T	□ Hernia	DATE of last Chest X-ray:______________
DATE OF LAST EYE EXAM:________________	□ Sexually transmitted disease	□ Palpitations
□ Disturbances of vision	□ Urinary Tract Infection	□ Blood pressure problems
□ Red or itchy eyes	□ Pain on urination	□ High cholesterol
□ Loss of hearing	□ Inability to hold urine	□ History or heart murmurs
□ Ringing in ears	□ Blood in urine	□ Swollen ankles or feet
□ Pain in ears	□ Urethral discharge	□ Blood clots
□ Disturbances of speech	***Women's Issues:***	***Central Nervous System:***
□ Trouble swallowing	DATE OF LAST PERIOD:__________________	□ Fainting
□ Sore or dry throat	TYPE OF BIRTH CONTROL:_______________	□ Convulsions
□ Lip or mouth sores	DATE OF LAST MAMMOGRAM:__________	□ Weakness/paralysis
□ Nosebleeds	□ Painful periods	□ Loss of feeling or function in body part
□ Nose or sinus problems	□ PMS	□ Disturbances of balance
□ TMJ	□ Irregular periods	□ Dizziness
□ Loss of taste or smell	□ Excessive bleeding	□ Light-headedness
□ Headache	□ Abnormal lack of menses	***Emotional:***
□ Problems with teeth/dentures	□ Hot flashes	□ Worry
DATE OF LAST DENTAL EXAM:___________	□ Vaginal dryness	□ Moodiness
Respiratory System:	□ Sexual difficulties	□ Irritability
□ Cough	□ Painful breasts	□ Nervousness
□ Asthma	□ Lumps in breasts	□ Depression
□ Chest pain	□ Pregnancy#___	□ Grief
□ Shortness of breath	***Skin and Hair***	□ Problems in relationships
□ Rib pain	□ Rash	
	□ Oozing skin sores	
	□ Eczema	
	□ Loss of hair	

Additions to Health History:

PATIENT SIGNATURE:____ DATE: ___________________________

Dr. Amy Wells
5470 Shilshole Ave NW #300
Seattle, WA 98107

Phone: 206-632-2154
Fax: 206-432-9509

Authorization to Release Confidential Health Information

I Hereby Authorize:

❍ Dr. Amy Wells
❍ Facility/Doctor's Name: ____________________
Address: ____________________
City: ____________________ State: __________ Zip: __________-________
Phone#: ____________________ Fax #: ____________________

To Release:

❍ Complete Chart Record *(does not include billing information or radiographic images)*
❍ Chart Notes: ❍All ❍Specify: ____________________
❍ Labs/Reports: ❍All ❍Specify: ____________________
❍ Billing Records: ❍All ❍Specify: ____________________
❍ X-rays/Radiographic Images(specify): ____________________
❍Other: ____________________

From the Health Records of:

Name: ____________________ Date of Birth: _____/_____/_________
Soc. Sec. Number: ____________________ Daytime Phone: ____________________ ext:: _______
Are you authorizing release of your own records? ❍Yes ❍No

Release of certain medical information requires a minor's consent. This applies to persons aged 13 to 17 for information pertaining to substance abuse and mental health information, or persons aged 14 to 17 for information pertaining to sexually transmitted diseases, HIV and AIDS. Other laws may apply.

To be Released to:

❍ Dr. Amy Wells ❍ **Self** (please provide address below if requesting a copy of your own records)
❍ Facility/Doctor: ____________________
Address: ____________________
City: ____________________ State: __________ Zip: __________-________
Phone #: ____________________ Fax #: ____________________

For the Purpose of:

❍Adjunctive/Concurrent Care ❍Transfer of Care ❍ Other: ____________________

I understand that unless revoked this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document..
Unless specifically excluded, this authorization includes release of specially protected information requiring my explicit authorization for release. This includes referral, diagnosis and treatment information related to:
(check the accompanying box(s) below to EXCLUDE the information from authorization)

❍ substance abuse ❍ mental health/psychotherapy notes ❍ sexually transmitted diseases and ❍ HIV/AIDS

I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided for by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would no longer be protected.

I understand that I do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of this authorization form at the time of signing. I may call Dr. Amy Wells at (206) 632-2154 to inquire about revoking this authorization.

I understand that if I request records for personal use, to hand-carry to another health provide, or for parties not involved in my health care, there may be a charge. 'Non-emergency' release of records may take up to 15 working days. Emergency requests will be given priority processing. 'Emergency' status applies only to release of records directly to another healthcare provider for urgent patient care. There is no charge to release records to another healthcare provider.

____
Patient's Signature

____
Guardian/Personal Representative's Signature

____
Patient's Name (PRINT)

____
Relationship to Patient

____
Date

____
Date

Dr. Amy Wells, ND PLLC
5470 Shilshole Ave NW #300
Seattle, WA 98107
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CLINIC POLICIES

Financial Policies (Revised 1/3/20)

Insurance Billing: You are required to provide proof of insurance coverage (insurance card) at the time of your visit. For patients with insurance coverage in which Dr. Wells is a participating provider, we bill insurance directly and accept their payment plus any co-payments, co-insurance, deductibles and payments for non-covered services as payment in full. If your policy has an office visit co-payment, you agree to pay the co-payment at the time of your visit. **Patients are responsible to know the terms of their insurance and whether naturopathic services are covered.** If services are not covered, patients are responsible for payment.

For patients with an insurance plan in which Dr. Wells is not contracted you will pay at the time of service and we will courtesy bill your insurance company. Please provide us with the necessary information. It will be your responsibility to follow-up with your insurance company should they deny payment for any reason. Keep in mind that you will receive statements from us until payment is received and that; ultimately your account balance is your responsibility.

Time of service discount: All patients paying in full at the time of service (TOS) will receive a 15% discount on office visit. This discount does not extend to non-service products such as supplements. If receiving a TOS discount, the visit cannot be submitted for insurance reimbursement and will not count toward your deductible.

Supplements return policy: Supplements may be returned, unopened, within 30 days of purchase for a credit on your account. Probiotics are not eligible for return.

Cancellation Policy:

- We require 48 hours notice to cancel or reschedule an appointment.
- We are closed on Saturday and Sundays. For Tuesday appointments, notice must be given on Friday.
- Appointment reminders are sent by email 5 days prior and a text is sent one day prior to your appointment.
- A fee is assessed for appointments cancelled in less than 48 hours, late arrivals 15 minutes or later, and no shows.
- Cancellation/NoShow Fee Schedule
    - New Patient Visit - $300.00
    - 60 Minute Return Office Visit - $250.00
    - 45 Minute Return Office Visit - $187.50
    - 30 Minute Return Office Visit - $125.00
    - Vaccination/Injection - $75.00
- Late arrivals of 15 minutes or more will be required to reschedule their appointment and will be assessed a “no show” charge as listed above.
- A patient with two or more “no shows” may be discharged from the practice.
- All patients scheduling first office visits, return office appointments, vaccinations/injections and dry needling are required to provide a credit card that we securely keep on file. This will be used to automatically charge for a late cancel/no show fee.
- I authorize Dr. Amy Wells, ND, PLLC to charge my No Show or Late Cancellation fee to my credit card on-file. I understand that this charge is my financial responsibility.

Returned Checks: We charge $35 for returned checks to cover banking costs. Patients who incur NSF/returned check charges will be required to make future payments by cash, credit card or cashier’s checks.

Multiple Households: When a child of divorced parents is seen, we will expect payment from whichever parent accompanies that child. We will not bill ex-spouses or parents who live outside the area.

INITIAL THAT YOU HAVE READ AND UNDERSTAND THE FINANCIAL POLICIES ABOVE: __________

Informed Consent to Treat
I hereby authorize qualified medical personnel to perform routine and emergency medical procedures as necessary to facilitate me or my child's diagnosis and treatment. This includes the following: common diagnosis procedures, minor office procedures, use of pharmaceutical, botanical, nutritional, and homeopathic medicine, manual/physical medicine, dry needling, trigger point injections, IVs, injections and immunizations. I recognize that there are potential risks and benefits of these procedures. This authorization will be in effect until revoked in writing by me.

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.

INITIAL THAT YOU HAVE READ AND CONSENT TO THE ABOVE: __________

Health Insurance Portability and Accountability Act (HIPAA)
I understand that Dr Amy Wells, ND will use and disclose health information about the patient in compliance with the HIPAA Act. I understand I am entitled to receive a copy of the Notice of Privacy Practices as outlined by Federal Regulations. I have the right to ask that some or all of the patient's health information may not be used or disclosed in the manner described in the Notice of Privacy Practices. My signature below acknowledges I am aware of my rights in accordance to HIPAA.
INITIAL THAT YOU WERE OFFERED A NOTICE OF PRIVACY PRACTICES:__________

Release of Health Information
We keep a record of the health care services we provide you and your child. You may ask to see and copy that record (copy charges may apply). We will not disclose you or your child's record to others unless you direct us to do so.

Pager Service
For urgent medical concerns after hours that cannot wait until the next business day you may contact the doctor on call. The number of the doctor on call is updated regularly on our office answering machine (206) 632-2154. If you do not receive a return call within 15 minutes please call again. If you have a medical emergency that cannot wait 15-30 minutes, call 911. Please note that there is a $75 fee for all pager calls. This service is not covered by health insurance plans. This service is for urgent medical needs only, please reserve calls for routine or non-urgent concerns to business hours.

Patient Portal/Communication
Patients are encouraged to sign up for a patient portal account. The portal allows you access to important chart information including lab results and medication and immunization records in addition to secure messaging with Dr. Wells. You will be sent an email invite to the email you provide. E-mail messages will only be accepted through the patient portal. Other forms of email or texting are not HIPAA compliant .If you are experiencing a new health symptom or concern, please contact the office to make an appointment. If you have an urgent medical need page the doctor or call the office..

I acknowledge that I have read and understand the information above.

_____/_____/_____
Date

____

Patient Name

____
Patient/Parent/Guardian Signature

____
Parent/Guardian Name