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.

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Pediatric Intake Form

Date: _____

Child's last name: _____ Child's first name: _____ M. I_____

Nickname(s): _____ Birthdate: _____ Gender : _____

Parent: _____ Parent: _____ _____

Sibling (s):_____ _____ _____

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

Besides mother and father, does anyone else take care of the child? No Yes Who? _____

Has the child received healthcare elsewhere? No Yes Where? _____ _____

Has the child been immunized? No Yes Which ones? _____

When? _____ _____

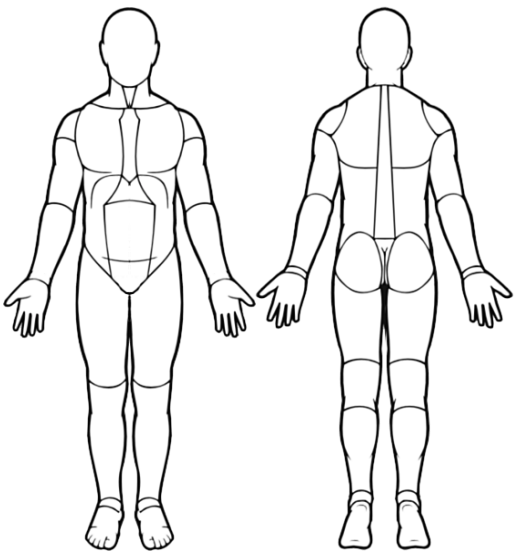
How would you rate this child's health in general? (Circle) Excellent Good Fair Poor

Do you have concerns about the child's behavior or development? No Yes What?_____

Do you have any concerns about the child's nutrition or growth? No Yes What?_____

Date of last well child exam: _____ Date of last blood tests: _____

PRESENT HEALTH CONCERNS

Please list most important health concerns in their order of significance.	Prior diagnosis of this problem? If so, what?	Indicate painful or distressed areas:
1.		
2.		
3.		
4.		

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

_____

Do you have any questions about our clinic or care? _____

Please list any prescription medications, over the counter drugs, supplements, vitamins, herbs, homeopathic remedies, etc that the child is currently taking with dosages: _____

_____

_____

Please list any allergies to medication or life threatening allergies and reaction_____

_____

Family health habits:

How often does your child use a seatbelt (car seat)? Never Rarely Sometimes Often Always

Does your child ride a bicycle? Yes No How often does she/he use a helmet? Never Rarely Sometimes Often Always

Does your home have smoke detectors? Yes No Carbon Monoxide detectors? Yes No

Does your home have a fire extinguisher? Yes No

Do you feel that you live in a safe place? Yes No In the past year, have you felt threatened in your home? Yes No

Do you have guns at home? Yes No If so, what kinds of guns are in your house? _____ N/A

If you have a gun at home, is it locked up? N/A Yes No

Does anyone in your household smoke? Yes No If yes, who? _____

What type of pets do you have in home?_____

Does your child follow any particular diet regimens or restrictions? If yes, please describe: _____

_____

_____

Past history: Please circle those that apply to child--

- € Frequent Ear Infections
- € Allergies, Hay Fever
- € Eczema, Psoriasis
- € Anemia
- € Heart Murmur
- € Vision Problems
- € Kidney or Bladder Infections
- € Seizures
- € Broken Bones
- € Hearing Problems
- € Bed Wetting
- € Injury or Abuse
- € Asthma
- € Pneumonia, Bronchitis, Persistent Cough

Family Medical History:
Please check the 'yes' box next to each condition that applies to the child's mother, father or other family members. Please note whether the condition is in the past or currently by denoting a 'P' for past, or 'C" for current. Indicate who had the condition in the 'Relation' column.

	YES	RELATION	DATE RESOLVED Past (P)/Current(C)		YES	RELATION	DATE RESOLVED Past (P)/Current(C)
Alcoholism/ Drug Addiction				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema				Other			
Epilepsy							

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

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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