



THE  
NATURAL PATH  
TO HEALING  
PRIMARY CARE, PAIN, AND AUTO INJURY CLINIC

## HEALTH HISTORY QUESTIONNAIRE - SHORT

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

<b>Name</b> <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB:</b>
<b>Social Security Number:</b>			
<b>Address:</b>		<b>City/St/Zip:</b>	
<b>Email address:</b>			
<b>Home Phone:</b>		<b>Cell Phone:</b>	
<b>Preferred method of contact:</b> <b>home phone / cell phone / other:</b>			
<b>Marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
<b>Previous or referring doctor:</b>		<b>Date of last physical exam:</b>	
<b>How did you hear about us:</b> Referred by: Phone book / Newspaper Ad / Brochure in community / Website <a href="http://www.thenaturalpathtohealing.com">www.thenaturalpathtohealing.com</a> /Google Ads/ American Association of Naturopathic Physicians Website/ Washington Association of Naturopathic Physicians Website / Saw Signs / Other			

### PERSONAL HEALTH HISTORY

**Childhood illness:**     Measles     Mumps     Rubella     Chickenpox     Rheumatic Fever     Polio

**PAST MEDICAL HISTORY (List any medical problems that other doctors have diagnosed and approximate date of diagnosis)**

#### Surgeries

Year	Reason	Hospital

#### Other hospitalizations

Year	Reason	Hospital

**List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers**


#### Allergies to medications

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### OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

## The Natural Path to Healing, LLC

### INSURANCE INFORMATION

\_\_\_\_\_ I do not have insurance or my insurance will not cover these services and I am paying cash. (Please skip to next page)

\_\_\_\_\_ Please bill my insurance and I will pay the remaining balance and copay.

My copay is: \$ \_\_\_\_\_

My insurance will cover \_\_\_\_\_ % of the services and I am responsible for the remaining.

#### **Insurance Information**

Insurance Carrier: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient's Phone #: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insurance Billing Address: \_\_\_\_\_

Insurance Phone #: \_\_\_\_\_

I, \_\_\_\_\_, certify that the above information is correct to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# The Natural Path to Healing, LLC

## SIGNATURE PAGE

### FINANCIAL POLICY

#### **PATIENT AUTHORIZATION AND UNDERSTANDING**

I have read and understand the financial policies of The Natural Path to Healing, LLC. I agree to abide by the terms of the financial policy. I request that payment of benefits be made to The Natural Path to Healing, LLC and hereby authorize the release of any information necessary to determine the liability of payment and obtain reimbursement on any claim. I further authorize the use of my signature below on all insurance submissions for services rendered or to be rendered. I agree that a photocopy of this agreement shall be as valid as the original. This authorization shall remain valid until revoked by me in writing and there has been a termination of services with The Natural Path to Healing, LLC.

PATIENT'S PRINTED NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

Patient's or Legal Guradian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of person completing form if other than patient: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

### CONSENT FOR 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 The Natural Path to Healing, LLC or the practitioner. 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 a 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 (see *Notice of Privacy Practices*) and that obtaining a copy of my record may require payment of a fee.

\_\_\_\_\_  
Guardian/personal Representative's Name (Print)

\_\_\_\_\_  
Patient's Name (Print)

\_\_\_\_\_  
Guardian/personal Representative's Signature

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Relationship/Representative's Authority

\_\_\_\_\_  
Date

### HIPAA

I hereby certify that I have received the *Notice of Privacy Practices* for **The Natural Path to Healing, LLC**. I understand that if I have objections or concerns with this policy, I must notify **The Natural Path to Healing, LLC** per the instructions in the *Notice of Privacy Practices*.

\_\_\_\_\_  
Name (printed)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# The Natural Path to Healing, LLC

## **Financial Policy**

Thank you for choosing The Natural Path to Healing, LLC for your care. We know you have many choices in providers and we appreciate your business. We look forward to a relationship with mutual trust and an opportunity to help you obtain optimal health. As you know, payment for services is part of your care and part of our professional relationship. We have developed a financial policy to make these obligations clear from the beginning.

### **CASH PAYMENTS**

Payment is due at time of service. The Natural Path to Healing accepts cash, checks and most major credit cards.

### **INSURANCE COVERAGE AND PAYMENTS**

We will gladly bill your insurance if you have a PPO or out-of-network coverage. It is your responsibility to obtain and verify this information prior to your scheduled appointment.

If you have a copay, this will be due at the time of service. If your insurance covers only a portion, it is your responsibility to pay the remaining balance that will be billed to you by the clinic after the 60-day grace period allotted to insurance companies by the state. If you have a deductible, this will be billed to you after receiving notification of payment from your insurance company.

In the event that your insurance coverage has changed, you will be responsible for the full cost of the office visit that is not covered by your insurance company. At that time, you may personally submit the bill to your insurance company for reimbursement.

### **THIRD PARTY PAYORS**

The Natural Path to Healing, LLC will submit to third party payors such as PIP. There will be a \$25 deposit due at the time of service, which will be reimbursed to you when payment is received. Please note that issues or conditions that are outside the parameters of your PIP coverage will need to be scheduled for a different visit on a different day.

### **PHONE CONSULTATIONS**

Phone visits can be scheduled and will be charged a flat rate of \$50 for each 1-15 minutes on the phone. The fee will be waived if it is determined that an in person office visit is required or if you are referred for emergency services. The fee will also be waived if it is a question limited to a current and documented treatment plan.

### **EMAIL CORRESPONDENCE**

Due to liability, email consultations are not permitted. If there is an extenuating circumstance, we may make exceptions. ***There will be a \$15 charge for each email received and responded to.*** You will be reminded of this charge prior to a response and an electronic acceptance of this charge will be required.

### **MISSED OR LATE CANCELLED APPOINTMENTS**

It is a professional courtesy to provide 24 hours notice if you cannot keep an appointment. ***There will be a \$50 charge for all appointments cancelled less than 24 hours in advance.***

If you are late to an appointment, please understand that you have a scheduled time and this may result in your appointment being cut short to remain within the parameters of your scheduled appointment time.

### **RETURNED CHECKS**

***There will be a \$25 fee for returned checks.*** Please note that you will still be responsible for charges and asked to pay with a different form (cash or credit/debit).

Thank you for your understanding and cooperation in our financial policies. As stated before, payment for services is part of your treatment and part of our professional relationship. This creates mutual respect and trust between physician and patient. We appreciated your support in helping us to continue to serve you and others.