

## Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home : (\_\_\_\_) \_\_\_\_\_ Work  
Ph:(\_\_\_\_) \_\_\_\_\_ Cell Ph:(\_\_\_\_) \_\_\_\_\_ **OK to leave voice-mail messages for you at above number?**  Home  Work  Cell  
Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Other names that records may be kept under: \_\_\_\_\_  
Mother's Name (minors only): \_\_\_\_\_ Father's Name (minors only): \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact's Phone #1: (\_\_\_\_) \_\_\_\_\_  Home  Work  Cell  
Do you have special needs?:  No  Yes

**How did you hear about us?**  Facebook  Twitter  Website  Workshop/Event  Green World Medical  Community Event  
 Friend/Family: \_\_\_\_\_  Little Nickel  B-Energized Clinic  Insurance Co.  Walk-In  Web Search

### Please notify us if your visit is related to an injury or accident

Does your plan require you to have a referral from your Primary Care Provider to receive coverage? Yes\* No

1. Primary Insurance Company & Plan Name: \_\_\_\_\_ ID Number: \_\_\_\_\_  
Group/Policy Number: \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_  
Policy Holder's Date of Birth: \_\_\_\_\_ The policy holder is my: \_\_\_\_\_ (relationship) Policy Holder's Gender (circle): M/F
2. Secondary Insurance Company & Plan Name: \_\_\_\_\_ ID Number: \_\_\_\_\_  
Group/Policy Number: \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_  
Policy Holder's Date of Birth: \_\_\_\_\_ The policy holder is my: \_\_\_\_\_ (relationship) Policy Holder's Gender (circle): M/F

## Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.**

X \_\_\_\_\_  
Guarantor's Signature Date

**The following information is requested for our grant and federal reporting requirements, but not required**

**Marital Status (circle one):** Single/Never Married Married Divorced Separated/Not Divorced Widowed Domestic Partnership

**Race/Ethnic Origin:**  African/African-American  Asian  Caucasian  Native American  Pacific Islander/ Native Hawaiian  Mixed Race  Other

**Number of members in your household:** \_\_\_\_\_ **Gross annual household income:** \_\_\_\_\_/year

## Terms of Admission

**Financial Terms:** I understand that if I am providing insurance billing information that I am responsible for all charges whether or not they are covered by my insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.

**Cancellation Policy:** I understand that Stone Turtle Health has a cancellation policy that charges a \$30 fee for no-shows or cancellations within 24 hours of a scheduled appointment. Further, I understand that the enforcement of this policy is at the sole discretion of Stone Turtle Health and the fee may be waived in cases of extreme weather conditions or other emergencies. Failure to cancel with more than 24 hours notice on more than one occasion may lead to being placed on a same-day scheduling list or termination of care with Stone Turtle Health. If care is terminated, all outstanding balances are required to be paid in full.

**Privacy Terms:** We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so. Stone Turtle Health is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish schedule an appointment to view your medical record, please call our medical records office at (206) 335-4309.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## CONSENT FOR TREATMENT

Stone Turtle Health, LLC 6204 8<sup>th</sup> Ave NW, Seattle, WA 98107 206.355.4309/206.297.6325

**Methods, Procedures and Therapeutic Approaches:** Clinicians may perform any of the following procedures as necessary to give proper assessments, determine treatment approaches, treat or otherwise address your health concerns.

**General Diagnostic Procedures** (including but not limited to venipuncture, pap smears, radiography, and blood and urine labwork, general physical exams, neurological and musculoskeletal assessments).

**Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions**

**Herbs/Natural Medicines** (prescribing of various therapeutic substance including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical creams, pastes, plasters, washes, suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.

**Dietary Advice and Therapeutic Nutrition** (use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.)

**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 and craniosacral therapy)

**Potential Risks:** Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

**Potential benefits:** 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. We do not use any labor-inducing substances unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a 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 Stone Turtle Health or any of its personnel regarding cure or improvement of my condition. 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 my representative or me or otherwise permitted or required by law.

\_\_\_\_\_  
Guardian/Personal Representative's Name (PRINT)

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

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

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

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

\_\_\_\_\_  
Date

STONE TURTLE HEALTH, LLC 6204B 8<sup>TH</sup> AVE NW, SEATTLE, WA 98107

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PATIENT PROFILE

Name (Last, First): \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

PRESENT HEALTH CONCERNS

Please list most important health concerns in their order of significance.	Prior diagnosis of this problem? If so, what?
1.	
2.	
3.	
4.	
5.	

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

Have you ever consulted a Naturopathic physician before?

Do you have any questions about our clinic or the care that you've chosen today? \_\_\_\_\_  
\_\_\_\_\_

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

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

List vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**Please list any severe or life-threatening allergies:** \_\_\_\_\_

Please explain reaction: \_\_\_\_\_

**Past History:**

Hospitalizations: \_\_\_\_\_

Serious Illnesses and Injuries: \_\_\_\_\_

Date of last physical/annual exam \_\_\_\_\_ Date of last blood tests: \_\_\_\_\_

**Social History:**

Please circle those that apply:    Single            Married            Significant other

Do you have any children?    Yes    No    Please list their age(s) \_\_\_\_\_