EVERGREEN
NATUROPATHIC

Where patient education is first and foremost...

Pediatric (0-17) New Patient Information Packet

~ Includes ~

Record of Disclosures, Patient Consent Form, Financial Consent Form

~ Location ~

We are located on the second floor of the Integrative Health Building

1801 W Broadway Ave, Suite 2

Spokane, Washington 99201

Office: 509.755.5100 x 1

Fax: 509.747.6646

Please note that Evergreen Naturopathic is a NO scent clinic
Please be mindful that some patients have severe allergies to scents

Services

Naturopathic Primary Care
Menopause, Thyroid & Hormone Balancing
Men's Health and Hormones
Telemedicine Consults
GI Health and Digestive Complaints
Nutrient Injections
Multiple Specialty Lab Tests
Management of Chronic Disease
Lyme Disease and Chronic Infections
Integrated Pain Management
Biopuncture/Scraping/Cupping/Neuro-Therapy/Perineural
Phone Consults
Naturopathic Soft Tissue Technique
Wellness and Preventative Medicine

Notice of NON-Covered Services

The following treatments, services, or laboratory testing are not or may not be covered by your insurance plan, your health savings plan, or reimbursed by any third party payer on your behalf. At Evergreen Naturopathic, we provide our patient base with a Superbill within 48-hours of their visit, for self-claim submission with their insurance company for any services rendered within our clinic. All additional specialty labs processed outside of our clinic would be able to provide proper documentation for your claims submissions, if they are a covered service.

Naturopathic Soft Tissue Techniques
Phone Consults
Telemedicine (Depending on Coverage)
Venipuncture (Blood Draws)
Specialty Testing
Nutrient Injections
Scraping|Cupping
Biopuncture
Neuro-Therapy
Trigger Point - Perineural

The reasons these services may not be covered could be but are not limited to the following:

1. The service is excluded from benefit plan coverage.
2. The service had not been authorized by the health plan.
3. This service may be determined to be a preventative, or wellness procedure not covered by third-party payers.
4. Deductible might not be met.

I hereby acknowledge that I understand the above services are not or may not be covered by the benefits available to me under the terms of my health plan, insurance policy, or any third-party payer.

I understand that I am financially responsible to pay for these services at the time of my visit or as instructed by Evergreen Naturopathic. I understand that for ALL services rendered in the clinic, full payment is due at check-out. I understand that there are no refunds for any testing, treatment, or service.

Print **Patient** Name: _____ **Date of Birth**: _____

Patient or **Legal Guardian** Signature: _____ **Date:** _____

Informed Consent To Treat | I hereby request and consent to examination and treatment with Naturopathic care, including various modes of physical therapy for: ___ Myself, or, _____, for whom I am responsible. I understand that there will be times during which I seek immediate treatment that my normal physician is not available and consent to be seen by any provider at Evergreen Naturopathic. I understand that this consent to care includes treatment received by nursing staff, medical assistants, phlebotomist staff and that they are at the direction of the providers.

I understand that naturopathic evaluation includes commonly used physical examination methods and movements to test bones, joints, nerves, muscles, organs and other tissues to help determine the diagnosis and course of treatment.

I understand that I am in full control of my body during the examination and it is my responsibility to inform the health care providers of any procedure I feel may cause injury or want to be stopped for any reason.

I understand that as a patient, I have a right to be informed about my condition and recommended care. This disclosure is to help me become better informed so I may make the decision to give or withhold my consent as to whether or not I want to undergo care after having had the opportunity to discuss potential benefits, risks, and hazards involved.

I understand that naturopathic evaluation and treatment may include, but is not limited to, various modes of physical therapy (ultrasound, diathermy, low volt electrical stimulation, hydrotherapy, heat, cold, traction, stretching, exercise, etc.) collecting specimens for laboratory evaluation including blood draws, cultures, and/or dietary therapy, biofeedback, and homeopathy.

I understand that naturopathic modalities continually change and that Evergreen Naturopathic seeks to keep pace with new and effective modalities and may add or stop providing certain services at any time.

I understand that at this time, the Food and Drug Administration has not yet approved nutritional, herbal, and homeopathic supplements but that they have been widely used in the US and Europe for many years.

I understand that as with drugs; nutritional supplements, herbal remedies, and homeopathic remedies may exhibit some side effects in certain sensitive individuals, may interact with certain prescribed medications or lab tests, or exacerbate symptoms in certain pre-existing disease conditions.

I do not expect the providers to be able to anticipate and explain all risks and complications. I wish to rely on the providers to exercise judgment in recommending treatment that the provider feels is right at the time, based on the facts then known, that are in my best interest.

I acknowledge that I have the opportunity to ask questions and discuss, to my satisfaction, with the provider the following;

1. **My suspected diagnosis or condition.**
2. **The nature, purpose, and potential benefit of the proposed care.**
3. **The inherent risks, complications, potential hazards or side effects of the treatment or procedure.**
4. **The probability or likelihood of success.**
5. **Reasonable available alternatives to proposed treatment/procedures.**
6. **The possible consequences if treatment advice is not followed and/or if nothing is done.**

I understand and am informed that in the practice of naturopathic medicine there are some risks of examination and treatment. **I further acknowledge** that no guarantees or assurances have been made to me concerning the results of treatment. **Potential risks**: allergic reactions to prescribed herbs and supplements, side effects of natural medications, healing reaction as defined below, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures. **Healing Reaction:** Natural healing may occasionally generate a "Healing/Detox/Herx Reaction." If this is anticipated, we will offer you specific information about this phenomenon. Generally this presents as flu-like symptoms, possibly with fever or a worsening of individual symptoms for a few days. **Notice to Pregnant Individuals:** 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 infancy. I hereby acknowledge that I have read, or have had read to me, and understand the above consent by signing below. **I consent to care.** I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment or care from Evergreen Naturopathic and its employees.

Print **Patient** Name: _____ **Date of Birth**: _____

Patient or **Legal Guardian** Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____

Notice of Privacy Practices

I acknowledge that I have received and read a copy of Evergreen Naturopathic's Notice of Privacy Practices.

Notice of Privacy Practices are available within Evergreen Naturopathic's lobby and website

Financial Consent / Billing Practices

I understand that in compliance with HIPAA, no billing information, including but not limited to balances, dates of services, and insurance information, will be released to a third party for patients over the age of 13 without a current third party release form on file.

I understand that I am responsible for the full amount of ALL services rendered via Telemedicine, Phone Appointment or physically in the clinic.

As of January 1, 2024, I understand that Evergreen Naturopathic will stop accepting insurance. I understand that I will be responsible for paying my bill in full at time of service. I understand that Evergreen naturopathic will be providing information and education that will aid me in the process of self-submitting my office visit charges to my insurance company. I understand that I can still utilize the benefits of my medical insurance but that Evergreen Naturopathic will no longer be billing my medical insurance for me. I understand that I understand that I can bill my insurance myself and that my medical insurance company MAY then reimburse me for my visit. I understand that there is no guarantee that I will receive reimbursement from my insurance company. I have been advised that Evergreen Naturopathic will provide me with a Superbill for self-claim submissions within 48-business hours of my appointment.

As of January 1, 2024, I understand that Evergreen Naturopathic provides a 10% discount to those who are retired or active duty Military or those who qualify for Medicare.

I understand that as of January 1, 2024, if I claim financial hardship and bring documentation that shows that I meet Federal Poverty Guidelines, that Evergreen Naturopathic will assist me in accessing care, by providing a 30% discount on my office visits.

I understand and acknowledge that if my account should contain an outstanding balance past due for more than 120 days, Evergreen Naturopathic will process my account to their collections agency **Associated Credit Services Inc.** 12815 E. Sprague Ave., Suite 200 Spokane, WA 99216 (509) 252-4600 for further collection arrangements.

Phone/Zoom Consultation Agreement: I understand that Phone Consultations are available on a self-pay basis only. I understand that payment at the time of service is required for telephone/Zoom consultations. You are required to have a credit card on file for the payment of the visit, if Reception is unable to reach you for the post-appointment check out process, you are authorizing your card to be charged for the full balance due.

Phone Or Elation Passport Consult|Messaging Policy: Physician, RN or MA on staff will return phone calls or Passport messages during business hours. Any consultation or message that exceeds 10 minutes will incur a charge of $65.00.

Establishing Care: I understand that my initial consultation is focused on obtaining a full history for establishing care and normally is a 60-minute visit. If I also state that I require an Annual Exam on the same day as my appointment to establish care, I understand that this will be an extended visit of 90 minutes and that I will be charged for the extended time.

I understand and acknowledge that ALL payments for visits/appointments will be paid in full at the time of service regardless of Telemedicine or in person visits.

Missed/Canceled Appointments: I understand that if I do not show up for an appointment, or do not cancel within at least 48 business hours (Established Patients) or 72 business hours (New Patient) business hours. I may not be able to reschedule and that I could be charged a fee of $100.00.

No Show Policy: New Patients, 1st missed appointment, we will not be able to reschedule you (This is a firm policy). Established Patients 1st missed appointment will be covered by your One-Time-Waive, 2nd missed appointment you will incur a fee of $100.00, 3rd missed appointment you will incur a fee of $100.00 and we will not be able to reschedule you again in clinic.

Formulary: I understand and acknowledge that there are no refunds for any items purchased from the Evergreen Naturopathic in-house formulary. Shopify and Fullscript are to be contacted directly for any return or refund requests, as we cannot confirm or deny approval of such requests.

Print **Patient** Name: _____ **Date of Birth:** _____

Patient or **Legal Guardian** Signature: _____ **Date:** _____

New Patient Intake Form

The information you provide here helps the provider understand your health more completely in order to help you attain your wellness goals. Please answer all questions as completely as possible.

Provider: Alycia Policani, ND ( ) Michael Lehman, ND ( ) David Graves, ND ( ) Maria Lams, ND ( )

Childs Name: _____Date of Birth: _____ Age: _____

Height: _____ Weight: _____

Pediatrician ***(required if under 13)***: _____ Phone: _____

- **Pronouns: (Please Circle)** He/Him/His | She/Her/Hers | They/Them/Theirs | Option Not Listed
- **Sex at Birth: (Please Circle)** Female | Male | Intersex/Other | Unknown
- **Identified Gender: (Please Circle)** Woman | Man | Transgender Woman/Trans Feminine | Transgender Man/Trans Male | Non-binary | Gender queer | Gender Fluid | Two-Spirit | Prefer Not to Say | Unknown | Option Not Listed
- **Sexual Orientation: (Please Circle)** Asexual | Bisexual | Gay | Lesbian | Straight | Queer | Prefer Not to Say | Unknown | Option Not Listed
- **Legal Gender Marker: (Please Circle)** F | M | X | Unknown

Mailing Address: _____

City, State, Zip: _____

Phone Number: _____May we leave detailed messages about medical information? ___Y ___N

Email: _____ ***We will never share your email with any third party.***

May we send you an email or text to confirm your appointment?____ Y ____N Cell Carrier: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Parents are: Married ___ Living Together ___ Separated ___ Divorced ___ Other ___

Parent/Guardian Name (s): _____

Home Phone:_____ Cell: _____

If different: Address:_____

City: _____State: _____ Zip:_____ Email: _____

How did you hear about Evergreen Naturopathic?

___ **Personal** Referral: Please provide their name so we may thank them: _____

___ **Business** Referral: Please provide their name so we may thank them: _____

___ Website ___Facebook ____Word of Mouth: ___ Print Ad: Other? _____

Patient Questionnaire

Present Health Concern|Reason for Appointment Today:_____

Medication/Supplements	**Dose** (ie; 5mg, 10mg, etc.)	**Reason for taking**	**How long?**
Pharmacy Preference (name and location):			

Allergies: *Please list any known allergies and reactions to them. If you do not have any, circle "none".*

Drugs/Medications: *None*	**Food:** *None*	**Environmental:** *None*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Lifestyle

Current Tobacco use: (Circle One) *None* *Daily* *Weekly* *Monthly* Amount? _____

Previous history of smoking? (Circle One) *Yes* *No* How long? _____ Quit Date? _____

Recreational Drug use? (Circle One) *None* *Daily* *Weekly* *Monthly* Type/Amount? _____

Estimate Daily Amounts of the Following: Water Intake: _____ Coffee/Black Tea: _____

Soft Drinks: _____ Alcohol: _____

Past and Current Medical History

Diseases, Ongoing issues, Major traumas, Hospitalizations, Surgeries, Serious Illnesses and Year of occurrence (if applicable):

_____

_____

_____

Please list any of your child's health concerns and/or current diagnosis:

_____

_____

What are your goals for your child in establishing care with us today?

_____

_____

Any complications or concerns regarding pregnancy and childbirth?

_____

Was your child breastfeed? Yes __ No __ Duration? _____

Has your child been vaccinated? Yes__ No __

Has your child had: X-Ray Yes __ No __ Cat Scan Yes__ No__ MRI Yes__ No__ Please describe:_____

What are your child's favorite hobbies and activities: _____

_____

What are your child's favorite foods? _____

_____

What type of pets do you own? _____

How would you rate your child's academic performance? _____

Is there anything else you would like us to know about your child? _____

_____

_____

Please indicate if your child has or has had the following:

❑ Eczema or psoriasis ❑ Asthma ❑ Diarrhea ❑ Nightmares ❑ Constipation ❑ Bed-wetting ❑ Finicky eating ❑ Warts

❑ Chronic Sniffles ❑ Tantrums ❑ Hyperactivity ❑ Fears/Phobias ❑ Growing Pains ❑ Stomach Aches

Patient Questionnaire Continued

Family History of Disease

Autoimmune Dz Specify Type		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family
Cancer		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family
Chemical Dependency		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family
Diabetes		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family
Heart Disease		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family
High Blood Pressure		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family
High Cholesterol		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family
Clotting/Bleeding Disorder		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family
Kidney Disease		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family
Mental Illness		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family
Stroke		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family
Osteoporosis		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family
Migraine Headaches		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family
Seizure Disorder		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family

I certify that the above information is correct to the best of my knowledge. I will not hold Evergreen Naturopathic responsible for any errors or omissions that I may have made in the completion of this form.

I acknowledge that I am financially responsible for all charges that may apply during the course of my care at Evergreen Naturopathic.

I acknowledge that if I am more than 10 minutes late to my appointment it will be counted as a missed appointment and I will be charged the $100.00 missed appointment fee.

Responsible Party, If Other Than Patient:_____ **DOB:** _____

Print **Patient** Name: _____ **Date of Birth:** _____

Patient or **Legal Guardian** Signature: _____ **Date:** _____

Patient Authorization for Use and Disclosure of Protected Health Information

By signing,_____ I Authorize Evergreen Naturopathic to disclose certain protected health information (PHI) about me to the following person(s):

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Narne:_____ Relationship:_____

Information to be released (initial all that apply):

____Diagnosed Conditions ____Labs, Imaging, and Other Test Ordered and/or Results
____Information Discussed During Office Visits Referrals
____Treatment Plans
____Supplements
____Billing Information/Balance Due
____Other_____

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

Patient Authorization:

I understand that my record may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases (STDs), sexual history, drugs and/or alcohol use/abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

****Exclude the following information from the records released (please initial)****

_____Drug/Alcohol use/abuse treaünent and diagnosis **_____Sexual history/STDs**

_____HIV/AIDS diagnosis/treatment/testing **_____Mental Illness diagnosis/treatment**

I do not have to sign this authorization in order to receive treatment from Evergreen Naturopathic. I have the right to make changes to or revoke this authorization in writing at any time. To review the process for revoking this authorization, please read the Privacy Notice posted at the facility where your information is being released.

Print **Patient** Name: _____ **Date of Birth:** _____

Patient or **Legal Guardian** Signature: _____ **Date:** _____

Informed Consent for Telemedicine Services

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Security

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits

- Improved access to medical care by enabling a patient to remain at a remote site
- More efficient medical evaluation and management
- Obtaining expertise of a distant specialist
- Maintaining patient safety during a pandemic or declared state/federal emergency

Possible Risks

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (ie. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions, allergic reactions, or other judgment

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information according to the patient medical records policies set by the clinic.

4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time.

5. I understand that my telemedicine appointment may involve electronic communication of my personal medical information to other medical practitioners if a referral is warranted.

6. I understand that it is my duty to inform my physician of electronic interactions regarding my care that I may have had with other healthcare providers.

7. I understand that I may expect the anticipated benefits from the use of telemedicine, but that no results can be guaranteed or assured.

8. I understand that telemedicine has its limitations, and that there is no guarantee that this telemedicine consultation will eliminate the need for me to see a health care provider in person. I agree to consult with a local health care provider in person for any necessary physical examinations.

By signing this form, I certify:

• That I have read or had this form read and/or had this form explained to me

• That I fully understand its contents, including the risks and benefits of telemedicine

• That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

• I hereby authorize (clinic name) and its medical staff to use telemedicine in the course of my diagnosis and treatment.

In the event that my telemedicine session is disrupted or distorted by technical failures, I would like to be contacted via telephone

at the following number: _____

Print **Patient** Name: _____ **Date of Birth:** _____

Patient or **Legal Guardian** Signature: _____ **Date:** _____