



Prosper Natural Health, PLLC

Welcome.

At Prosper Natural Health we provide safe, effective, affordable, and sustainable health solutions. Working together, we can achieve your optimal health, by combining state-of-the-art medicine with natural, traditional, health care.

The following forms are included in this packet:

- Notice of Privacy Practices Acknowledgement
- HIPAA Rights
- Payment Agreement
- Informed Consent
- Patient Introduction Form

**Please complete these forms prior to your scheduled appointment.
This will allow you to get the most of our your appointment.**

Your Visit:

Our clinic is located at the end of Decatur Street, directly on the waterfront. You will find it to your right when you are facing the water. Prosper Natural Health & Prosper Bodyworks are handicap accessible. Handicap parking is conveniently located directly in front of Prosper Natural Health.

The first visit is typically averages from 60-90 minutes. This visit includes a health status interview and a physical exam, which may be required to formulate a diagnosis and treatment plan specifically for you.

Follow up visits are typically scheduled for 15-45 minutes, and follow-up appointments can be made by calling (360)385-5375 or in person.

Client Fees: *Fees are re-evaluated at the beginning of each calendar year.*

Initial Consult	\$35 (15 minute introductory consult available to new patients, to ensure naturopathic treatment is correct option. This charge is credited back to you at the time of your initial intake visit.)
Initial Intake Visit	\$250 per hour (minimum of \$250)
Follow Up Visit	\$250 per hour (minimum of \$100)
Blood Draw	\$35
IV Nutrition or Injection	\$20 B12; \$25 B12+Folic acid or B-complex
Telemed/Telephone Consultations (for established patients under special circumstances in lieu of an office visit)	\$62.50 per 15 minutes, minimum of \$85 <i>No charge if patient is calling at physician request or for clarification of on-going therapy.</i>
Lab & Dispensary Fees	Vary depending on treatment/labs ordered. (Due to the individualized nature of your treatment, there is no standard set of tests run on every patient. Fees for lab work are due at the time of sample collection, and all pricing is available prior to service.)

We look forward to serving your unique health concerns and needs.



Notice of Privacy Practices Acknowledgement

Please Fill Out and Return

I received a copy of the Notice of Privacy Practice, and I have been provided an opportunity to review it.

Name _____ Date of Birth _____

Signature _____ Date _____

HIPAA Rights
Please fill out and Return

Your Health Information Privacy Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds.
- To obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please check all that apply:

- Please do not phone me at home. Use this alternate phone number: _____
- Please do not phone me at work. Use this alternate phone number: _____
- Please do not leave messages on my answering machine.
- Please do not contact me by email.
- Please send mail, including my bills, to this alternate address:

- Other request (please describe): _____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

Date: ____ / ____ / ____

Patient Signature (Parent/guardian signature if minor)



Payment Agreement

Please fill out and Return

Dear New Client,

Welcome to Prosper Natural Health. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care.

Please read and initial the following statements:

_____ Payment for all services and medicinary items is due at the time of the visit. We accept cash, checks, Visa, or MasterCard. Returned checks will be subject to a \$50.00 NSF fee.

_____ The physicians of Prosper Natural Health, PLLC do not currently contract with any insurance companies for the care provided at Prosper Natural Health. If your plan has coverage for out of network naturopathic care we will provide you with the appropriate coding to submit your own claim.

_____ You will be charged a Missed Appointment Fee of \$50.00 for any missed appointments or late cancellations (less then 24 hours notice).

Your health care provider may prescribe medication, which may be purchased at Prosper Natural Health or elsewhere. Most insurance companies do not cover the pharmacy items that we prescribe and dispense.

I have read and understand the above-stated policies of Prosper Natural Health, PLLC and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

Patient Signature (Parent/guardian signature if minor) Date: ____ / ____ / ____

Informed Consent

Please fill out and Return

I _____ hereby acknowledge that I am accepting treatment from a Naturopathic Doctor at Prosper Natural Health, PLLC. The state of Washington licenses Naturopathic Doctors as primary care physicians (PCP).

1. I understand that there are differences between the care provided by Naturopathic Doctors (NDs) and by Medical Doctors (MDs).
2. I understand that consulting with a Naturopathic Doctor does NOT mean that I should discontinue appropriate standard medical care.
3. I also understand that, as with standard medical treatment, there is no guarantee that this treatment will offer complete resolution to any or all conditions that I may have.

At this time it is my decision to pursue Naturopathic treatment for my health conditions. I hereby affirm that I consent and agree to the above statements of my own free will and request to engage the services of the Naturopathic Doctors at Prosper Natural Health, PLLC and to participate in a professional relationship with them pursuant to the statements herein.

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

Date: ____ / ____ / ____

Patient Signature (Parent/guardian signature if minor)

Date: ____ / ____ / ____

Physician/Witness

New Patient Introduction

Please fill out and Return

This is a confidential record of your medical history. Please complete this questionnaire as thoroughly as possible to ensure you get the most from your visits. Your time, thoughtfulness, and honesty in completing this form will greatly aid me to assist you with your health needs.

Full Legal Name: _____ **Date:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone # (home): _____ **(work):** _____ **(cell):** _____

May we leave confidential voice-mail messages for you at any of the above numbers? No / Yes (specify): Home / Work / Cell

E-mail address: _____

Age: _____ **Date of Birth:** _____ **Gender:** female / male / other

Emergency contact: _____

Relationship: _____ **Phone:** _____

Address: _____

How did you hear about our clinic? _____

If internet: Google: _____ **AANP Website:** _____ **WANP Website:** _____ **Other:** _____

Has any other family member already been a patient at the clinic? _____

Why did you choose to come to this clinic?

What do you know about our approach?

What three expectations do you have from this visit to our clinic?

What long term expectations do you have for working with our clinic?

What expectations do you have of me personally as your physician?

How much experience do you have with “complementary and alternative medicine”?

None 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 Significant

What is your attitude toward “complementary and alternative medicine”?

Very skeptical 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 Extremely interested

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

0% 0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits?

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols that we will be sharing with you?

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

What do you love to do?

What are your most important health problems? List as many as you can in order of importance:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

Do you have any known contagious diseases at this time? Yes / No

If yes, what? _____

Allergies

List if you have hypersensitive or allergies to...

Any drugs? _____

Any foods? _____

Any environmental or chemical? _____

Current Medications

Do you currently take or use? (please circle "Y" for yes and "N" for no)

Laxatives	Y / N	Pain relievers	Y / N	Sleeping pills	Y / N
Cortisone / Steroids	Y / N	Appetite suppressants	Y / N	Antacids	Y / N
Tranquilizers	Y / N	Thyroid medication	Y / N	Blood Pressure Meds	Y / N
Antibiotics	Y / N	Birth control pills	Y / N	Antifungals	Y / N

Please list **all** prescription medications, over the counter medications, vitamins or other supplements you are taking. Please include the dosage.

Please bring your medications & supplements bottles to your first appointment.

- 1) _____ 7) _____
- 2) _____ 8) _____
- 3) _____ 9) _____
- 4) _____ 10) _____
- 5) _____ 11) _____
- 6) _____ 12) _____

Who, if any, healthcare providers do you see? (Please include provider name and facility name)

Family History

Do you have a family history of any of the following? (please circle)

Asthma/Hay fever/Hives	Diabetes	Heart Disease	High Blood Pressure
Kidney Disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness

Cancer (Type: _____)

Any other relevant family history? _____

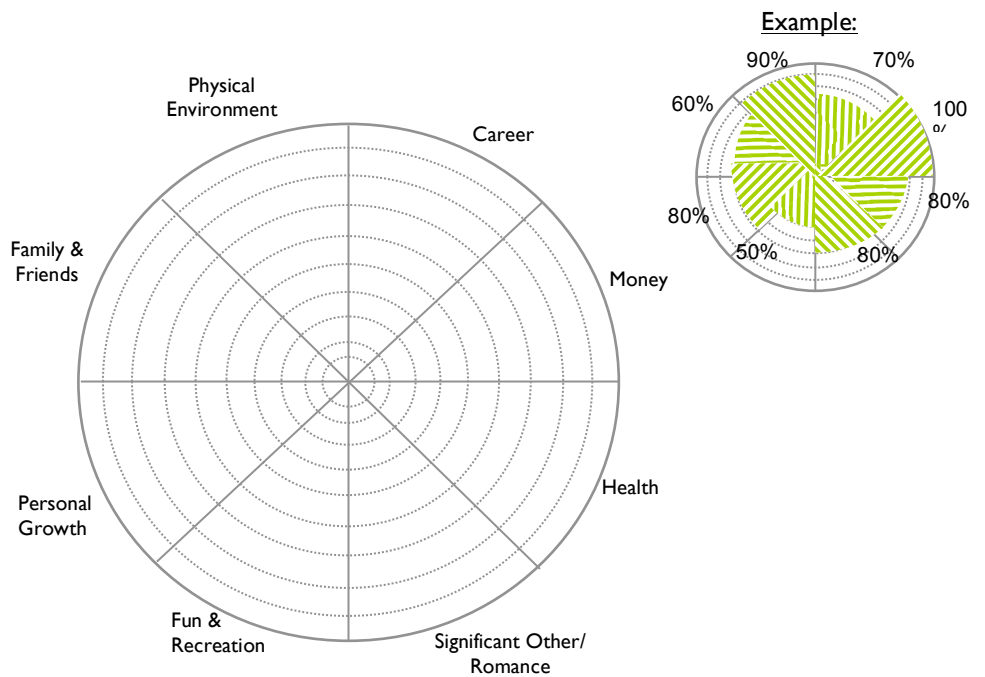
What is your ethnicity? _____

Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.



Finished. Thank you for your time and effort

213 Decatur Street, Port Townsend, WA 98368 • ProsperNaturalHealth.com

Phone: (360)385-5375 • Fax: (360)329-7831