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
- ☐ Pediatric Intake

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 *No charge if patient is calling physician request or for clarification of on-going therapy.*
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 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.)

_____ Date: ____/____/____

Patient Signature (Parent/guardian signature if minor)

Informed Consent

Please fill out and Return

I _____ hereby acknowledge that I am accepting treatment from a Naturopathic Doctor at Prosper Natural Health. 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 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

Pediatric Intake

Please fill out and Return

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

Patient 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

Parents Names: _____

Emergency contact: _____

Relationship to patient: _____ 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?

1. _____
2. _____
3. _____

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

What expectations do you have of me personally as your child's 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 child's 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 does your child currently engage in regularly that you believe support health?

What behaviors or lifestyle habits does your child currently engage in regularly that you believe are unhealthy lifestyle habits?

What obstacles do you foresee in addressing your child's health and in adhering to the therapeutic protocols that we will be sharing with you?

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

What does your child love to do?

List the child's health concerns and symptoms in order of importance.

1.
2.
3.
4.
5.

SYMPTOMS: Check any symptom the patient has had in the last 12 months.

General
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Muscle/Joint/Bone

Pain, weakness, numbness in (please circle):

Arms Back
Legs Feet
Hips Hands
Neck Shoulders

Eyes, Ears, Nose, Throat
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Sore throat

Genito-Urinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Gastrointestinal
- ☐ Poor appetite
- ☐ Belching
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas / Flatulence
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Reflux
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Respiratory
- ☐ Cough, persistent
- ☐ Shortness of breath
- ☐ Wheezing

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Swelling of ankles
- ☐ Varicose

Skin-related
- ☐ Bruise easily
- ☐ Dandruff
- ☐ HHives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal
- ☐ Wart(s)
- ☐ Eczema/psoriasis veins

Does your child have any known contagious diseases at this time? Yes / No

If yes, what? _____

Please describe (indicating the date) any serious illnesses, hospitalizations, or operations:

_____

_____

_____

_____

Date of last physical exam: _____

Current/Previous Conditions

Please indicate any condition(s) you have been diagnosed as having:

☐ ADD/ADHD	☐ Cataracts	☐ Heart disease	☐ Migraines	☐ STDs
☐ Alcoholism	☐ Diabetes	☐ Hepatitis	☐ Miscarriage	☐ Strep throat
☐ Anemia	☐ Emphysema	☐ Hernia	☐ Mitral Valve Prolapse	☐ Stroke
☐ Anorexia	☐ Epilepsy	☐ Herpes		☐ Suicide Attempt
☐ Anxiety	☐ Fibromyalgia	☐ High Blood Pressure	☐ Multiple Sclerosis	☐ Thyroid Disease
☐ Appendicitis	☐ German Measles	☐ High Cholesterol	☐ Mumps	☐ Tonsillitis
☐ Arthritis	☐ Chemical Dependency	☐ HIV/AIDS	☐ Pacemaker	☐ Tuberculosis
☐ Asthma	☐ Chickenpox	☐ Hives or Eczema	☐ Pneumonia	☐ Typhoid Fever
☐ Back/Neck Pain	☐ Crohn's Disease	☐ IBS	☐ Polio	☐ Ulcer
☐ Bladder Infection	☐ Depression	☐ Infectious Mono	☐ Prostate Problem	☐ Ulcerative colitis
☐ Bleeding Disorders	☐ Glaucoma	☐ Kidney Disease	☐ Psychiatric Care	☐ Vaginal Infections
☐ Breast Lump	☐ Goiter	☐ Liver Disease	☐ Rheumatic Fever	☐ Venereal Disease
☐ Bronchitis	☐ Gonorrhea	☐ Low Blood Pressure	☐ Rubella	☐ Whooping Cough
☐ Bulimia	☐ Gout	☐ Lupus	☐ Scarlet Fever	☐ Other (please list):
☐ Cancer		☐ Measles	☐ Schizophrenia	

Birth

☐ Home	☐ Hospital	☐ Birthing Center	☐ Vaginal	☐ Caesarian	☐ Premature
Complications:					
Weight:	Length:				
Breastfed? _____	Until? _____	If formula, which?			
Age at which solid foods were introduced:					

Immunization History	Date	Boosters
Tetanus		
Measles-Mumps-Rubella (MMR)		
Varicella (Chicken Pox)		
Hepatitis A		
Hepatitis B		
Diptheria- Pertussis (Whopping Cough)		
Flu shot		
HIB		
Pneumococcal		
Rotavirus		

Social & Lifestyle

Tobacco/Drug/Alcohol/Caffeine use? _____

Regular exercise (type)? _____ How much? _____

Travel outside of the United States? _____ Where/When? _____

School: _____ ☐ Home ☐ Public ☐ Private

Lunch away from home (at school or other)_____

After-school activities? _____

Daycare? _____

Pets? _____

ALLERGIES: List if your child has hypersensitive or allergies to…

Any drugs? _____

Any foods? _____

Any environmental or chemical? _____

CURRENT MEDICATIONS: (please circle "Y" for yes and "N" for no)

Laxatives	Y / N	Pain relievers	Y / N	Sleeping pills	Y / N
Cortisone / Steroids	Y / N	Attention Deficit medication	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 your child is 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 does your child see? (Please include provider name and business name)

_____

_____

_____

FAMILY HISTORY: Does your child 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 child's ethnicity? _____

Thank you for your time and effort.