Karl Peterson DC, ND
Narrows Natural Health Clinic
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Patient Admittance Form

Confidential Patient Information Date: _____

First Name: _____ MI: _____ Last: _____

Minor's Parent/Guardian Name: _____

Marital Status: ☐ Single ☐ Married ☐ Other Spouse/Partner Name: _____

Patient DOB: _____ Patient SSN: _____ Referral by: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

Mailing Address

Street: _____ Unit: _____

City: _____ State: _____ Zip: _____

Employment/School Status Employer: _____ School: ☐Part-Time ☐Full-Time _____

Emergency Contact Information

Name: _____ Phone: _____

Email: _____ Relationship: _____

☐ *Insurance – Provide Card(s)* ☐ NONE – Cash Patient ☐ Auto Accident* ☐ Work Injury*

*Supplemental information required. Please request forms.

Patient Current Condition(s)/Concern(s)

Please list any current symptom(s) you may have in order of importance

1. _____
2. _____
3. _____
4. _____

Patient History

Are you seeing anyone else for other problems or health conditions? ☐ No ☐ Yes

Please list the problem/s, date problem/s began, and Provider/s treating you for the condition/s:

	Problem/Condition	Date Began	Provider Seen
1.			
2.			
3.			
4.			

Past Health History

Are you seeing anyone else for other problems or health conditions? ☐ No ☐ Yes

Have you been:	No	Yes	Date Seen	Provider Seen
1. Hospitalized in the last 5 years?	☐	☐		
2. Diagnosed with Diabetes? ☐ Type I ☐ Type II	☐	☐		
3. Treated for hypertension?	☐	☐		

Do you smoke or use tobacco products? ☐ Never ☐ Former ☐ Current Frequency: _____

Do you consume alcohol? ☐ Never ☐ Former ☐ Current Frequency: _____

Surgery(s)	Year
1.	
2.	

Serious illnesses and/or accidents with cause	Year
1.	
2.	

Do you have allergies – food, environmental and/or medication(s)? ☐ No ☐ Yes

Type of Allergy	Reaction
1.	
2.	

Do you eat a special diet? ☐ No ☐ Yes

If yes, please describe: _____

Please list chemicals, metals, dust or fumes you are repeatedly exposed to, or which you were repeatedly exposed to in the past:

Name of chemicals, metals, dust or fumes — Dates of Exposure

1. _____ _____
2. _____ _____

How many hours do you:

Work/Week: _____

Sleep/Night: _____ Quality of Sleep: _____

Exercise/Week: _____ Type of Exercise: _____

Do you use a contraceptive? ☐ No ☐ Yes Type: _____

Have you or any biological family member(s) had any of the following?

Self	Family	Condition	Self	Family	Condition	Self	Family	Condition	Self	Family	Condition
☐	☐	Allergies	☐	☐	Cancer	☐	☐	Hearing Loss	☐	☐	Macular Degeneration
☐	☐	Alcoholism	☐	☐	Diabetes	☐	☐	High Blood Pressure	☐	☐	Nervous/Mental Disorder
☐	☐	Asthma	☐	☐	Epilepsy	☐	☐	Hypoglycemia	☐	☐	Tuberculosis
☐	☐	Bleeding Tendency	☐	☐	Heart Disease	☐	☐	Kidney Disease	☐	☐	Other: _____

Have you ever had any of the following?

Self	Condition	Self	Condition	Self	Condition	Self	Condition
☐	Back Trouble	☐	Fractures	☐	Hot Flashes	☐	Thyroid Disorder
☐	Blood Disorder	☐	Gall Bladder Disorder	☐	Liver Disorder	☐	Trouble with Sleep
☐	Cataracts	☐	Hepatitis C	☐	Loss of Sex Drive	☐	Ulcers, Peptic
☐	Car Accident(s)	☐	HIV	☐	Stroke	☐	Other: _____

What stress-reducing activities do you do regularly? _____

Are you willing to change your living habits to improve your health? ☐ No ☐ Yes

For Women

Date of last PAP: _____ Date of last Mammogram: _____ Date of last menstrual cycle: _____

Duration of cycle: _____ Number of children: _____ Ages: _____

Pregnancies:

Deliveries: _____ Complications: _____

Miscarriages: _____ Complications: _____

Abortions: _____ Complications: _____

Medications

What medications are you currently taking? Include vitamins, herbs, minerals and other over-the-counter remedies.
Please be as specific as possible, listing the Date Started, Brand or Generic Name, Strength, Dosage, Frequency, Duration, Quantity, # of Refills Available, and Prescribing Physician.

Date Started	Medication	Strength	Dosage	Frequency	Duration	Quantity	# Refills	Prescribing Physician

Other medications taken over the last 5 years

Date Started	Medication	Strength	Dosage	Frequency	Duration	Quantity	# Refills	Prescribing Physician

I authorize the doctors and staff at Narrows Natural Health Clinic to examine and treat my condition(s), which may include diagnostic testing deemed necessary for my care, medication(s) and/or therapy.

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself, and that I am ultimately responsible for any and all expenses incurred at Narrows Natural Health Clinic.

Payment is expected at time of service unless otherwise negotiated in writing.

Past due accounts (60 days or more) are subject to 1% late fee.

_____ _____

Patient or Parent/Guardian Signature Date

Financial Policy

Thank you for choosing Naturopathic/Chiropractic health care as an aid in maintaining your health. We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. The following is a statement of our policy, which we require that you read, agree to, and sign prior to any treatment.
All supplies, vitamins and labwork are to be paid at time of purchase.
All patients without insurance coverage will be expected to pay for services, supplies and labwork each visit.
As a patient with insurance you hereby authorize the direct assignment of all applicable medical benefits from your insurance coverage to Narrows Natural Health Clinic. You are financially responsible for all charges including the cost of Collection Agency fees, whether your insurance company pays or not. Narrows Natural Health Clinic is hereby authorized to release all necessary information to secure payments of benefits and use the signature below on all insurance submissions whether manual or electronic.

All patients with insurance are expected to pay copays and non-covered services each visit. Co-insurance charges will be billed accordingly after receipt of explanation of benefits/payments by your insurance company.

If we are your Primary Care Provider and you need a referral to see another Provider, you must obtain your referral PRIOR to your first appointment with the referred Provider. Referrals cannot be backdated.
Please note: You are responsible for knowing the terms, limitations and policies of your insurance coverage. This includes knowing if and when a referral to our clinic, or any other, is needed and which conditions are excluded from coverage. There are certain tests and treatments that are within the scope of Naturopathic practice, but are not covered by insurance when performed by a Naturopathic physician. You will be required to pay for these services up front and will be given receipts for tax purposes or submitting to insurance for possible reimbursement.
WE RESERVE THE RIGHT TO CHARGE FOR MISSED OR CANCELLED APPOINTMENTS WITHOUT 24 HOUR NOTIFICATION. Please refer to our posted Cancellation and Missed Appointment Policy. Charges for missed or cancelled appointments will NOT be billed to your insurance company. They are YOUR responsibility and will be due and payable on your next visit or upon receipt of the bill, whichever comes first.
Thank you for understanding our financial policy. Please let us know if you have any concerns or questions.
Please sign and date below.

Signature of Responsible Party _____ Date _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it *Notice of Privacy practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: ☐ Self ☐ Other: _____

Signature: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Initials: _____

Reason: ☐ Refusal to Sign ☐ Other: _____