

Patient Information

Name _____ Birthdate _____
Address _____ Home Phone _____
City _____ State _____ Zip Code _____ Cell Phone _____
Gender €M €F Age _____ Year in School _____ €Married €Single €Minor €Life Partner
Patient Employer/School _____ Occupation _____
Email address: _____
Whom may we thank for referring you? _____
In case of emergency who should be notified? _____ Phone _____
May we leave confidential voicemails regarding appointments or labwork? €Yes €No _____
Dr. Aasan is an Affiliate Clinical Faculty member of Bastyr University, and occasionally has a student observing visits. Would you feel comfortable having a Naturopathic medical student present at your visit? €Yes €No

Billing Information

Person Responsible for Account _____
Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address (if different from patient's) _____ Phone _____
City _____ State _____ Zip code _____
Person Responsible Employed by _____ Occupation _____
Insurance Company _____
Member/ID # _____ Group # _____
Names of other dependents covered under this plan _____
Is patient covered by additional insurance? €Yes €No If yes, please provide insurance card to receptionist.

Authorization and Agreement of Payment

I hereby certify that all of the above information is true. I agree to have medical information released for billing purposes to my insurance carrier and to billing personnel. I understand that I am responsible for knowing and understanding my insurance policy and benefits, and that I am responsible for any copays, deductibles or services not covered by my insurance plan. If the balance of this account is not paid within 30 days, a \$5.00 per month rebilling fee will be applied (per RCW 18.62). I have read the above and understand that I am responsible for all medical and financial charges.

Signature of patient, parent, guardian or personal representative

Date

Please print name of patient, parent, guardian or personal representative

Relationship to patient

Adult Health History Questionnaire

Thank you for taking the time to fill out this health history form. Understanding your total health picture is essential for us to help you achieve optimum wellness.

Name _____ M/F _____ Date of Birth _____ Today's Date _____

Current health concerns (in order of importance)	Date of onset
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Health goals:

What factors do you feel are contributing to your current state of health? _____

Current medications (include brand and dose):	Current supplements (include brand and dose):

Primary Care Physician: _____ Phone number: _____

Are you establishing primary care? _____

Other health care practitioners (i.e. medical specialists, acupuncturist, chiropractor, counselor, other specialists)

Name	Type of practice	Phone number

Date of last physical exam	Date of last pap/gyne exam	Date of last fasting blood labs
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Previous medical diagnosis: _____ Diagnosed by _____ Date of diagnosis _____

Hospitalizations, Surgeries, Injuries, or Serious Illnesses (appendix, fractures, accidents):

Year: _____ Event: _____ Location: _____

Have you ever had a blood transfusion? Yes/No

Severe or life threatening allergies, and their result (i.e. anaphylaxis, skin reaction) _____

Non-life threatening allergies and reaction to them (mold, animals, grass, foods) _____

Are you fully vaccinated? _____ If not, please describe which vaccinations you have had and include approximate dates (flu shot?): _____

When was your last tetanus booster, and did it contain pertussis (TdaP)? _____

Have you had any of the following in the **past year**:

General	Genito-urinary	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Itching
<input type="checkbox"/> Chills	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Nausea	<input type="checkbox"/> Ear ache	<input type="checkbox"/> Mole change
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Pain	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Rash
<input type="checkbox"/> Fever	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Sore(s)
<input type="checkbox"/> Loss of sleep	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Nosebleed	Women
<input type="checkbox"/> Numbness	Gastrointestinal	<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Abnormal Pap
<input type="checkbox"/> Sweats	<input type="checkbox"/> Bloating/Gas	Cardiovascular	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Bleeding
<input type="checkbox"/> Weight loss or gain	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Sinus problems	between period
Musculoskeletal	<input type="checkbox"/> Constipation	<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Vision problems	<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Pain	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Rapid heart beat	(what?)	<input type="checkbox"/> Nipple discharge
<input type="checkbox"/> Weakness	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Ankle swelling	Skin	<input type="checkbox"/> Vaginal discharge
<input type="checkbox"/> Numbness	<input type="checkbox"/> Excessive thirst	EENT	<input type="checkbox"/> Bruising	<input type="checkbox"/>
Where?	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Hives	<input type="checkbox"/>

Is there anything important that is not specifically listed above that you have experienced in the past year? _____

PHYSICIAN USE ONLY, DESCRIBE HISTORY ABOVE: _____

Have you, or a close family member (parents, grandparents, siblings, aunts, uncles, children) ever had any of the following? Please use whatever space you need to describe any details you know. If there is not enough room in the chart, there is space below for more details.
 If you do not know your family history, please explain why (adopted, out of communication, etc.)_____

	Self (when?)	Family (who?)			Self (when?)	Family (who?)
<input type="checkbox"/> Allergies/hay fever				<input type="checkbox"/> HIV		
<input type="checkbox"/> Anemia				<input type="checkbox"/> Infertility		
<input type="checkbox"/> Alcoholism/ Substance abuse				<input type="checkbox"/> Inflammatory Bowel Disease (Crohn's, Ulcerative colitis)		
<input type="checkbox"/> Alzheimer's				<input type="checkbox"/> Irritable Bowel Syndrome		
<input type="checkbox"/> Anxiety				<input type="checkbox"/> Kidney/bladder disease		
<input type="checkbox"/> Arthritis				<input type="checkbox"/> Learning disability		
<input type="checkbox"/> Asthma				<input type="checkbox"/> Liver/gallbladder disease		
<input type="checkbox"/> Bipolar disorder				<input type="checkbox"/> Lupus		
<input type="checkbox"/> Bleeding disorder				<input type="checkbox"/> Mental illness		
<input type="checkbox"/> Blood pressure problems				<input type="checkbox"/> Migraine headache		
<input type="checkbox"/> Breast lump				<input type="checkbox"/> Mononucleosis		
<input type="checkbox"/> Bronchitis				<input type="checkbox"/> Multiple sclerosis		
<input type="checkbox"/> Cancer (type, age of death or recovered)				<input type="checkbox"/> Neurological disorder (Parkinson's, paralysis)		
				<input type="checkbox"/> Obesity		
<input type="checkbox"/> Chronic Fatigue Syndrome				<input type="checkbox"/> Osteoporosis		
<input type="checkbox"/> Cholesterol, high				<input type="checkbox"/> Pneumonia		
<input type="checkbox"/> Circulatory problems				<input type="checkbox"/> STD (type)		
<input type="checkbox"/> Colitis				<input type="checkbox"/> Stroke		
<input type="checkbox"/> Decreased sex drive				<input type="checkbox"/> Suicide (attempt)		
<input type="checkbox"/> Depression				<input type="checkbox"/> Thyroid problem (hypo or hyper)		
<input type="checkbox"/> Diabetes				<input type="checkbox"/> Tuberculosis		
<input type="checkbox"/> Diverticulosis/itis				<input type="checkbox"/> Ulcer		
<input type="checkbox"/> Eating disorder				<input type="checkbox"/> Urinary tract infection		
<input type="checkbox"/> Epilepsy				<input type="checkbox"/> Varicose veins		
<input type="checkbox"/> Emphysema				Women only	Self (when?)	Family (who?)
<input type="checkbox"/> Environmental sensitivity				<input type="checkbox"/> Abnormal PAP		
<input type="checkbox"/> Fibromyalgia				<input type="checkbox"/> Breast cancer		
<input type="checkbox"/> Food intolerance				<input type="checkbox"/> Endometriosis		
<input type="checkbox"/> Genetic disorder				<input type="checkbox"/> Fibrocystic breasts		
<input type="checkbox"/> Glaucoma				<input type="checkbox"/> Fibroids		
<input type="checkbox"/> Heartburn				<input type="checkbox"/> Menstrual irregularity		
<input type="checkbox"/> Heart disease				<input type="checkbox"/> Miscarriage		
<input type="checkbox"/> Hepatitis				<input type="checkbox"/> Pelvic inflammatory disease		
<input type="checkbox"/> Hernia				<input type="checkbox"/> Vaginal infections (yeast, BV)		
				<input type="checkbox"/> Other:		

Is there anything important in you or your family's past medical history that is not listed above? _____

Has anyone in your immediate family passed away? If yes, who, at what age, and from what cause? _____

Menstrual and pregnancy history:

Age of first period:
Date of last period:
Cycle length (i.e. 28 days):
Length of periods/bleeding:
Date of last pap: Normal?
Date of last mammogram: Normal?
Menopause? When?
Do you do self breast exams? How often?
Form of birth control:

PHYSICIAN USE:

G: A: P: T: L:

Number of total pregnancies:
Number of births, name, dates, gender, delivery: (example: Alex, 1-1-01, male, induced vaginal birth at 42 weeks)
Vaginal/C-section/Forceps/Vacuum/twins?
Pregnancy complications or miscarriage? What? Which pregnancy?

Health Habits

Exercise (type, how often, for how long): _____

Diet:

Type (i.e. Vegetarian, Omnivore, organics): _____
Food Restrictions/reactions: _____

Typical Breakfast	Lunch	Dinner

Fluids (type and amount per day, filtered water?)

Caffeine? How much?

Snacks: _____

Social:

What is your heritage? _____ Spirituality: _____
Are you single/married/in a relationship? _____ How would you describe your relationship? _____

Who else lives with you? _____
How old is your house/apartment? _____ Lead pipes/paint/radon? _____
Do you work inside or outside the home, describe: _____
What is your highest degree of education? _____
How does stress affect your life? _____

Do you smoke, drink alcohol, or use recreational drugs (how often and how much)? Please include past history too: _____
Toxic exposures – recent and past (i.e. lead, mercury, solvents, pesticides, radiation, asbestos, second hand smoke) _____

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS QUESTIONNAIRE!

Dr. Candace Aasan
Dr. Anna Evershed
12911 - 120th Ave NE, Ste E-50, Kirkland, WA 98034
Phone: 425-820-7700 • Fax: 425-820-7707



Financial Policy and Fees

Thank you for choosing Cascade Natural Medicine as your partner in healthcare. We will do our best to provide you with the highest quality medical services. We feel that it is very important that our patients have a clear understanding of our expectations regarding billing and payment. Please read and sign the following financial policy prior to your visit. If you have any questions or would like clarification, please feel free to ask.

1. Insurance: Please understand that your insurance policy is a contract between you and your insurance carrier, whereas your bill with your doctor is an agreement between you and your doctor. It is your responsibility to know what your policy covers and what it does not. If your insurance plan requires that you have a referral to see us, it is your responsibility to make sure you have the referral on file with your insurance company before your appointment here. If your insurance covers Naturopathic medical care, we will bill them for you. You must pay the co-payment, deductibles and payments for non-covered services as payment in full.

Co-payments must be made at the time of service.

2. Fees: We are committed to providing the best treatment for patients and charges are based on a value scale developed by the American Medical Association and is supported by most insurance companies. Medical billing depends on the complexity of an office visit and what was done for each patient. You are welcome to know what the charge is for any given service. The Emergency Pager use fee is \$25. Phone consultation fees range from \$25-50 depending on time spent on the consultation. These are services you may take advantage of if necessary. Insurance companies *do not* cover these services; the patient is responsible for these fees.

3. Non-covered services: Some, and perhaps all, of the services you receive or request may not be covered by your insurance company or not be considered reasonable and necessary. Some examples of typically non-covered services are vaccine counseling, nutritional counseling, emergency pager fees, telephone visits, and travel counseling.

4. Payment policy: Payment is expected at the time of service. This includes any unmet deductible amounts, co-payments, fees for services not covered by insurance, and pharmacy fees. Keep in mind that you will receive statements from our office until all payments are received and that ultimately your account balance is your responsibility. A \$5 rebilling fee will be assessed if there is failure to make payment or make contact with us within 30 days. If your account is over 90 days past due, you will receive a letter stating that you have 14 days to pay your account in full. Failure to pay will result in your account being referred to collection services and you and your immediate family will be discharged from this practice. A \$25 dollar fee will be charged to your account for NSF checks. When a child of divorced parents is seen, payment is expected from whichever parent accompanies that child to the visit.

5. Appointments: Please show up for your scheduled appointment on time. If you are unable to make your appointment, please give our office 24 hours notice so that we may reschedule your visit. Less than 24 hours notice for cancellation or "no shows" will be assessed a missed appointment charge of \$50. This charge is your responsibility, as insurance companies do not pay for missed appointments.

I acknowledge that I have read and fully understand this financial policy. I agree to the above stated fees and charges. All of my questions have been answered.

Signature of patient or responsible party

Date signed

Dr. Candace Aasan
Dr. Anna Evershed
12911 - 120th Ave NE, Ste E-50, Kirkland, WA 98034
Phone: 425-820-7700 • Fax: 425-820-7707



**NATUROPATHIC MEDICINE
INFORMED CONSENT FOR TREATMENT**

I, _____, hereby authorize Dr. Candace Aasan and/or Dr. Anna Evershed to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g., venipuncture, Pap smears, radiography, laboratory, x-ray.

Minor office procedures: e.g., cleaning, dressing a wound, ear lavage, skin scraping, skin cryotherapy.

Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.

Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, cremes, plasters, or suppositories.

Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.

Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

Vaccination, Psychological Counseling, Contraception, Pharmaceutical prescriptions

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of medications or vaccinations, aggravation of pre-existing symptoms, discomfort, pain, infection, burns, nausea, light headedness, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures. Notify Dr. Aasan, Dr. Evershed or the staff of Cascade Natural Medicine if you experience any symptoms which may be secondary to the above procedures.

Potential benefits: restoration of health and the body's maximal functional capacity without the use of drugs or surgery, 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 as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Candace Aasan, Dr. Anna Evershed, or any personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

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 myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

Signature of Patient

Date

Signature of Patient Representative or Guardian

Original: Chart
Copy: To patient (if requested)

Dr. Candace Aasan
Dr. Anna Evershed
12911 - 120th Ave NE, Ste E-50, Kirkland, WA 98034
Phone: 425-820-7700 • Fax: 425-820-7707



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Dr. Candace Aasan and/or Dr. Anna Evershed has made available to me or provided me with a copy of the Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

**Office Manager/Privacy Officer
425-820-7700**

I also understand that I am entitled to receive updates upon request if the Notice of Privacy Practices is amended or changed.

Signature

Relationship to Patient
(if signed by someone other than patient)

Date

**THIS SECTION IS TO BE COMPLETED IF UNABLE TO OBTAIN WRITTEN
ACKNOWLEDGMENT FROM PATIENT**

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

Patient declined to sign this Written Acknowledgment.

Other (specify): _____

Name and title of employee

Date