

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 lab work? Yes No

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

Pediatric Health History—Page 1

Date of Visit: _____
 Date of Birth _____ Time of Birth: _____
 Child's Name: _____ M / F
 Your Name: _____
 Relationship to Child: _____

Reason for visit? _____

Date of last physical exam: _____
 Does child have a primary care physician/other health care providers? Please list.

Vital Information:

Child's Birth date _____ Boy Girl
 Birthplace: City/State _____
 Home Hospital / Birth Center _____
 Mother's Name _____ Birth date: _____
 Occupation _____ Ht _____ Wt _____
 Father's Name _____ Birth date: _____
 Occupation _____ Ht _____ Wt _____
 Names of living brothers and sisters _____ Birth dates _____

Family Background

Ethnic origin/Race: Mother: _____ Father: _____
 Married Living together Separated Divorced Single
 Child lives with:
 Both parents Mother Father Guardian
 Other members of household: _____
 Age of home or apartment: _____ Any pets? _____
 Has any parent, brother, or sister died? _____ Who? _____
 Cause of death _____ Age _____

Was child adopted? Yes No At what age? _____
 If adopted, country of origin _____

Religious Preference

Pregnancy History

Number of pregnancies before this one: _____
 How long was this pregnancy? _____ weeks
 How many months pregnant when prenatal care was begun? _____
 Were there any of the following illnesses or problems?
 Rubella (measles) Accident / Injury Bleeding
 High blood pressure Swelling Sugar in urine
 Excessive weight gain Other infections
 Explain: _____
 Medicines or supplements used during pregnancy: _____

Smoking while pregnant: None Moderate Heavy
 Alcohol while pregnant: None <1 per week >1 per week

Birth Information

How long was labor? _____ Was labor induced? _____
At delivery (check all that apply):
 Breech (feet or bottom first) Cesarean section VBAC
 Breathed and cried immediately Resuscitated In oxygen
Did baby require:
 special nursery blood transfusion antibiotics lights
Did baby have:
 breathing problems yellow jaundice Other _____
At birth:
 Weight: _____ Length: _____ Apgar score _____
 Discharge weight: _____ Length of hospital stay: _____
 Did baby receive Vit K Hep B vaccine newborn screening tests
Describe any problems with birth or first days of life _____:

Please check the box of your child's blood relatives who have ever had any of the following conditions; circle examples in parentheses or write in name of disease, if known:	Father	Mother	Father's side	Mother's side	Siblings
Headaches (migraine, cluster, tension)					
Eye Disease (blindness, tumor, glaucoma)					
Ear Disease (deafness, infections, defects)					
Allergies (eczema, hay fever, sinus, hives)					
Lung Disease (asthma, cystic fibrosis, bronchitis).					
Tuberculosis					
High Blood Pressure.					
High Cholesterol					
Heart Attack (age _____).					
Heart Disease.					
Anemia (Sickle Cell, Mediterranean, other).					
Bleeding Disorders (hemophilia).					
Stomach or Duodenal Ulcers.					
Liver or Gallbladder Disease (hepatitis).					
Intestinal Disease (colitis, polyps).					
Kidney Disease (nephritis, cysts, stones).					
Diabetes.					
Thyroid Problems (goiter, nodules, hyper-, hypo-).					
Bone or Joint Disease (arthritis, osteoporosis).					
Muscle Weakness or Dystrophy.					
Seizure Disorder (epilepsy).					
Neurologic Disorder.					
Learning Disability.					
Mental Retardation (Down Syndrome, other).					
Mental Illness (depression, anxiety, other).					
Alcoholism or Drug Abuse.					
Birth Defects (cleft lip, other deformity).					
Obesity.					
Cancer: Breast, Cervix, Uterine, or Ovarian.					
Lung, Thyroid, Pancreas, or Kidney.					
Bladder, Prostate, or Testicular.					
Colon, Stomach, or Oral Cavity.					
Leukemia, Myeloma, or Lymphoma.					
Skin, Brain, or Bone.					
Other _____					

Pediatric Health History—Page 2

Infant Nutrition

Breastmilk Duration _____ weeks / months / years
 Avg number of nursing episodes/24 hours, currently _____
 Formula Brand _____ Oz/day _____ Age of first use _____

Problems: Vomiting Colic Diarrhea Allergies
 Uses Pacifier Uses Bottle **Solid foods:** Age when started _____

Childhood Nutrition: What has your child eaten over the past day?

Breakfast: _____
 Lunch _____
 Dinner _____
 Snacks _____
 Fluids _____

Favorite foods

Protein foods: _____
 Fruits: _____
 Vegetables: _____
 Grains: _____

Sleep and Elimination

Bowel movements: _____
 Urination/day or wet diapers/day: _____
 Where/with whom/ how does child sleep?
 Shared room or bed? Crib? Cosleeper? Bunk bed? On tummy or back?

 Typical Bedtime: _____ Wake time: _____ #wakings/night _____
 Naps: _____ Sleep problems? _____

Medical history

Please check the diseases that your child has had and give age:

Measles, Rubella _____ Anemia _____
 Mumps _____ Heart Disease _____
 Chickenpox _____ Allergies / Hay fever _____
 Whooping cough _____ Eczema _____
 Scarlet fever _____ Asthma _____
 Rheumatic fever _____ Pneumonia _____
 Convulsions/Seizures _____ Hepatitis _____
 Strep throat _____ Ear Infection _____
 Other illnesses: _____

Has your child ever been injured? _____ Age _____

Injury: _____

Any fractures? _____ Which bone(s)? _____

Any loss of consciousness or concussion? _____

Any accidental poisoning? _____ Age _____ Substance _____

Has your child ever had surgery? _____ Age _____

Type of operation _____

Has your child ever been hospitalized other than for the above? _____

Describe: _____

Has your child ever had a blood transfusion? _____ Age _____

Has your child worn:

Glasses Contact lenses Dental braces Leg braces
 Corrective shoes Orthotics in shoes Other braces

Please list all medications and supplements:

Does your child have allergies to any of the following?

Drugs _____
 Foods _____
 Environment _____

Please check if your child has had:

Frequent headaches Crossed eyes
 Pinkeye More than two earaches a year
 Trouble hearing Frequent nosebleeds
 Stuffy nose most of time More than 6 colds a year
 Chronic cough Shortness of breath with exercise
 Heart murmur Constant or frequent fatigue
 Frequent stomachaches Frequent diarrhea or constipation
 Poor appetite Frequent urination or accidents
 Bloody, red, or brown urine Frequent bed-wetting after age 5
 Joint pains or swelling Dizziness or fainting spells
 Inability to get to sleep Frequent nightmares or sleepwalking
 Excessive thirst Excessive weight gain
 Signs of sexual development before age 9

Other concerns: _____

Child Development

At what age did your child:

Sit alone _____ Walk alone _____ Feed self _____

Talk (2-3-word sentences) _____ Dress self _____

Toilet trained: Day _____ Night _____

School-age child: Current grade _____ Days missed this year _____

School Problems: reading, writing behavior special needs

Are there any behavior problems at home? _____

Please describe: _____

Immunizations and Screenings

Immunizations up to date on standard schedule
 Selective immunizations and/or delayed schedule
 Please provide copy of immunization record.

Please give approximate dates for the following, if done:				
Test	No	Yes	Date(s)	Result
Lead blood test				
TB skin test				
Vision exam				
Hearing test				
Hemoglobin blood test				
Urine test				
Other:				

Dr. Sheila Kingsbury
Naturopathic Physician
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 Dr. Sheila Kingsbury as your partner in healthcare. Dr. Kingsbury is an independent physician at Cascade Natural Medicine. Your physician will do her best to provide you with the highest quality medical services. 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 Dr. Kingsbury 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: Dr. Kingsbury is 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. Home visits or house calls are \$160 per hour. 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 Dr. Kingsbury 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. Sheila Kingsbury
Naturopathic Physician
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**NATUROPATHIC MEDICINE
INFORMED CONSENT FOR TREATMENT**

I, _____, hereby authorize Dr. Sheila Kingsbury, an independent physician at Cascade Natural Medicine, 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 your doctor 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. Sheila Kingsbury 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)

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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. Sheila Kingsbury 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 Dr. Kingsbury amends or changes the Notice of Privacy Practices in a material way.

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