Today's Date:

Registration Form

Patient Information

Name (Last, First, M.I.):			Maiden name:
	DOB:		M F
Street Address	City	St	Zip
Preferred Contact Number: Home Work Cell			
Home Phone	Work Phone	Cell Phone	
Marital status: Single Partnered Married Separated Divorced Widowed	Emergency Contact and Phone:		

Employer

Employer Name
Employer Address

Primary Insurance

Insurance Company Name:		Co-pay:
Subscriber's ID:		Group Number:
Subscriber's Name:		Subscriber's employer:
Subscriber's DOB:	Subscriber's sex: M F	Relationship to Subscriber:

Secondary Insurance

Insurance Company Name:		Co-pay:
Subscriber's ID:		Group Number:
Subscriber's Name:		Subscriber's employer:
Subscriber's DOB:	Subscriber's sex: M F	Relationship to Subscriber:

Responsible Party (who is in responsible for any balances on this account?)

Self Parent Guardian L & I Worker's Comp. Employer Contract

	Name (Last, First, M.I.):		
Street Address	City	St	Zip
Home Phone	Work Phone	Cell Phone	
Worker's Compensation/ L&I Claim Number:		Date of Injury:	
Employer Name:			

Referred By (how were you referred to Yakima Integrative Health?)

Insurance directory Website Yellow pages Friend Relative Physician

Whom may we thank? Name

I, the patient or guarantor, certify that the information on this form is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service unless other arrangements are made. I authorize physician and clinic to release any information to process insurance claims. I authorize my insurance claim to be paid directly to the clinic.

Signature:	Date:

Initial Health History Questionnaire

All information obtained is strictly confidential and will become part of your medical record.

Name (Last, First): _____

Preferred name: _____ Date of Birth: _____

Reason for visit: _____

What are your goals for your health? _____

_____

Previous Diagnoses: _____

_____

_____

_____

Medications and Supplements (dosage):

_____

_____

_____

_____

_____

Allergies (reaction):

_____

_____

_____

_____

_____

Surgeries and Hospitalizations:

_____

_____

_____

_____

_____

Medical History

Condition:	Self	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Allergies	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Autoimmune	☐	☐	☐	☐	☐	☐
Cancer (specify type)	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐

YIIH YAKIMA INTEGRATIVE HEALTH

Diet and Lifestyle

Describe your diet: _____

_____

Number of servings per day:

Water ____ Dairy ____ Whole Grains ____

Meat ____ Fruit ____ Sweets/Soda ____

Fish ____ Vegetables ____

Stress level from 1 - 10 (10 = highest): _____

How do you manage your stress? _____

_____

In the past 2 weeks, have you had little interest or pleasure in doing things? ☐ Yes ☐ No

In the past 2 weeks, have you felt down, depressed, or hopeless? ☐ Yes ☐ No

Habits:	Daily	Weekly	Monthly	Rarely	Never	Past
Alcohol	☐	☐	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	☐	☐
Toxic Exposures	☐	☐	☐	☐	☐	☐

Are you currently sexually active?

☐ Yes ☐ No

Gender of partners:

☐ Male ☐ Female ☐ Both

Are you currently trying to get pregnant?

☐ Yes ☐ No _____

Type of contraceptive

Review of Symptoms (experienced in the last 3 months)

Eyes

- ☐ Blurred vision
- ☐ Loss of vision

EENT

- ☐ Nosebleeds
- ☐ Sinus problems
- ☐ Seasonal allergies
- ☐ Decrease in hearing
- ☐ Frequent ear infections
- ☐ Ringing in ears

Respiratory

- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing

Cardiovascular

- ☐ Chest pain
- ☐ Heart palpitations or irregular heartbeat
- ☐ High blood pressure
- ☐ Swelling in legs
- ☐ Varicose veins

Gastrointestinal

- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Gas/bloating
- ☐ Hemorrhoids
- ☐ Change in appetite
- ☐ Nausea or vomiting
- ☐ Yellowing of skin

Genutourinary

- ☐ Painful urination
- ☐ Urinary urgency or frequency
- ☐ Blood in urine

Musculoskeletal

- ☐ Back or neck pain
- ☐ Joint pain
- ☐ Muscle aches

Neurological

- ☐ Dizziness
- ☐ Headaches
- ☐ Numbness or tingling
- ☐ Fainting
- ☐ Tremors
- ☐ Memory loss

Mental Health

- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

Men's Health

- ☐ Testicular pain or swelling
- ☐ Difficulty with erection or ejaculation
- ☐ Urination at night

Women's Health

- ☐ Heavy periods, irregularity, spotting
- ☐ Hot flashes or night sweats
- ☐ Breast tenderness, lumps, nipple discharge

Age of first menses: ____

Number of pregnancies: ____

Number of live births: ____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Yakima Integrative Health respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment:
Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you. We may also provide information to others providing your care. This will help them stay informed about your care.

For payment:
We may request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed or recommended care.

For health care operations:
We use your medical records to assess quality and improve services.

We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.

We may contact you to remind you about appointments and give you information about treatment alternative or other health-related benefits and services.

We may use and disclose your information to conduct or arrange for services including: medical quality review by your health plan, accounting, legal, risk management and insurance services, audit functions including fraud and abuse detection and compliance programs.

Your Health Information Rights:

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have a right to:

Receive, read and ask questions about this Notice; Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request, but we will comply with any request granted; Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information; Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing; Have us review a denial of access to your health information-except in certain circumstances; Ask us to change your health information. You may

give me this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included with any release of your Records. When you request, we will give you a list of disclosure of your health information. The list will not include disclosures of third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request information more than once in 12 months. Ask that your health information be given to you by another means or at another location. Please sign, date and give us your request in writing; Cancel Prior authorizations to us or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes you cannot cancel an authorization if its purpose was to obtain Insurance.

Our Responsibilities

We are required to: Keep your protected health information private; Give you this Notice; Follow the terms of this Notice. We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.

To Ask for Help or Complain
If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact: Yakima Integrative Health. If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to Yakima Integrative Health. You may also file a complaint with the U.S. Secretary of Health and Human Services. We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

-Notification of Family and Others
Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts. You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use or disclose your protected health information with out your authorization as follows:

With Medical Researchers if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.

To funeral Directors/Coroners consistent with applicable law to allow them to carry out their duties.

To Organ Procurement Organizations (tissue donation and transplant) or persons who obtain, store or transplant organs.

To the Food & Drug Administration in relation to problems with food, supplements and products.

To Comply With Workers' Compensation Laws if you make a makes workers' compensation claim.

For Public Health and Safety Purposes as Allowed or Required by Law to prevent or reduce a serious, immediate threat to the health or safety, to public health or legal authorities, to protect health and safety, to prevent or control disease, injury or disability, to report vital statistics such as births or deaths.

To Report suspected Abuse or Neglect to public authorities

To Correctional Institutions if you are in jail or prison, as necessary for your health and the health and safety of others.

For Law Enforcement Purposes such as when we receive a subpoena, court order or other legal process, or you are the victim of a crime.

For Health & Safety Oversight Activities. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.

For Work-Related Conditions That Could Affect Employee Health. For example, an employer may ask us to assess health risks on a job site.

To the Military Authorities of U.S. and Foreign Military Personnel. For example, the law may require us to provide information necessary to a military mission.

In the Course of Judicial/Administrative Proceedings at your request, or as directed by a subpoena or court order.

For Specialized Government Functions. For example, we may share information for national security purposes.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

The **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or Legally authorized individual signature	Date Time
Printed Name if signed on behalf of the patient	Relationship (parent, legal guardian, representative)

This form will be retained in your medical record.

Yakima Integrative Health
307 S. 12th Ave, Ste 9; Yakima, WA 98902
P: 509.469.2483 F: 509.469.8870

CONSENT FOR TREATMENT - Acupuncture

General Information: Dr. Heidi J. Robel, ND, LAc, PC is a licensed Naturopathic Physician and Acupuncturist. Due to the diversity of modalities the Dr Robel offers your treatment may include any or all of the following general modalities: Acupuncture and Oriental medicine, Naturopathic Medicine, Physical Medicine, Homeopathy, Psychological Counseling and Nutritional Counseling.
Methods, Procedures and Therapeutic Approaches: Your physician may perform any of the following procedures as necessary to give proper assessments, determine treatment approaches, treat or otherwise address your health concerns.
General Diagnostic Procedures (including but not limited to venipuncture, pap smears, radiography, and blood and urine lab work, general physical exams, neurological and musculoskeletal assessments)
Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions
Acupuncture: (insertion of special sterilized needles at specific point on the body)
Topical Treatments and Prepping: (includes cupping – a technique using glass cups on the surface of the skin with usually a heat created vacuum; and Gua Sha – rubbing on an area of the body with a blunt, round instrument)
Herbs/Natural Medicines (prescribing of various therapeutic substances including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures – may contain alcohol; topical crèmes, pastes, plasters, washes, suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substances may also be used.)
Dietary Advice and Therapeutic Nutrition (use of foods, diet plans or nutritional supplements for treatment – may include intramuscular vitamin injections.)
Soft Tissue and Osseous Manipulation (use of massage, neuro-muscular techniques, muscle energy stretching as well as manipulation of the extremities and spine including traction and craniosacral therapy)
Electromagnetic and Thermal Therapies (induces the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, infrared and ultraviolet therapies or moxa – warming or indirect burning of an acupuncture point and hydrotherapies)
Potential Risks: Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needles insertions, topical procedures, heat or friction therapies, electromagnetic and hydrotherapies,; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; a dn aggravation of pre-existing symptoms.
Potential Benefits: Restoration of health and the body's maximal functional capacity, 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, since some of the therapies used could present a risk to the pregnancy. We do not use labor-stimulating acupuncture points or any labor-inducing substances unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Heidi J. Robel, ND, LAc, PC or any of its personnel regarding cure or improvement of my condition. 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 my representative or me or otherwise permitted or required by law.

Guardian/Personal Representative's Name (PRINT)	Patient's Name (PRINT)
Guardian/Personal Representative's Signature	Patient's Signature
Relationship/Representative's Authority	Date
Date	

Yakima Integrative Health
307 S 12th Ave, STE 9
Yakima, WA 98902
P: 509-469-2483 F: 509-469-8870

CONSENT FOR TREATMENT - NATUROPATHIC CARE

I give permission for Yakima Integrative Health (Drs Dunlap, Nauman and/or Robel) to give me medical treatment.

I allow Yakima Integrative Health providers to file for insurance benefits to pay for the care I receive.

I understand that:

- Yakima Integrative Health will have to send medical information to my insurance company.
- I must pay my share of the cost.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand that:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

Signature: _____ Date: _____

Parent/Guardian (if under 18)_____ Date: _____

Print Name: _____

Yakima Integrative Health
307 S. 12th Ave, Ste 9; Yakima, WA 98902
P: 509.469.2483; F: 509. 469.8870

Additional Consent and Release Form

Please list any other parties who can have access to your medical information. (This includes parents, step parents, grandparents, and any care takers who can have access to your records.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize contact from this office to confirm my appointments, treatment, and billing information via:

- o Cell Phone Confirmation
- o Home Phone Confirmation
- o Work Phone Confirmation
- o Text Message to my Cell Phone
- o Email Confirmation
- o U.S. Mail/Postcard
- o Any of the above

I authorize information about my appointments and medical health to be conveyed via:

- o Message on Cell Phone
- o Message on Home Phone
- o Message on Work Phone
- o Text Message
- o Email Message
- o U.S. Mail/Postcard
- o Any of the above

I approve being contacted about special services, events, or new medical info via:

- o Phone message
- o Text message
- o Email
- o U.S. Mail/Postcard
- o Any of the above

Date: _____

_____ _____

Please print your name Please sign your name

_____ _____

Legal Representative Description of Authority

YAKIMA INTEGRATIVE HEALTH
307 S. 12TH AVE, STE 9
YAKIMA, WA 98902
509 469-2483

OFFICE POLICIES

Welcome! Thank you for selecting Yakima Integrative Health for your health care needs. Please take a few moments to familiarize yourself with our policies.

Office Hours

Monday – Friday 9-5PM

Payment Policy

Payment is required at the time of service. For your convenience, we accept cash, personal checks, MasterCard and Visa debit/credit.

Insurance Billing

Currently, we accept most Premera and Regence Insurance. Any co-pay is due at the time of service. Deductible and co-insurance fees are also the patient's responsibility. We ask that you check with your insurance provider before your first appointment to confirm coverage as naturopathic and acupuncture services vary among insurances. At this time, Medicare does not cover our services.

Missed Appointments

If you need to reschedule your appointment, please give us 24 hours' notice. We charge $75 for appointments missed or canceled in less than a 24-hour notice.

Telephone Consultation

We are happy to answer short questions and clarify instructions from a previous visit on the phone without charge. If you have a question about a new topic or a change in condition, please make an appointment.

Appointment Rates

Appointment rates vary by service and provider. Please inquire with the front desk for specific information.

Office Policies Agreement

I, _____ have read the above office policies and understand them.

Date_____ Signature _____

307 S. 12th Ave, Ste 9 Yakima, WA 98902 www.yakimaintegrativehealth.com.
509.469.2483

Financial Agreement

I, _____, being a patient of _____ located at the Yakima Integrative Health in Yakima, WA do hereby acknowledge that my health insurance policy is an arrangement between the Health Plan and myself.

I understand it will be my responsibility to understand my insurance policy and its benefits before arriving to my appointment. I also understand that certain services and tests may be ordered by the doctors located at Yakima Integrative Health which may not be covered by my insurance. I agree to be financially responsible for these services and tests.

Annual exams and dual licensed providers
If medical treatment is requested during an annual physical exam, I understand that my provider is allowed to bill the insurance carrier for those services separately from the annual exam charge. I also understand that if my provider is credentialed as both an acupuncturist and naturopath and both modalities are used during the visit my provider will also bill both visits separately.

Important questions to ask yourself before your appointment:

Do I have naturopathic benefits?
If not you will be responsible for paying at the time of your visit. A 20% time of service payment discount is offered to patients paying out of pocket.

Do I have a co pay? What percentage of my visit is covered by my insurance and do I have a deductible?
Co-pays are due at the time of service. Deductible and co-insurance fees are also a patient responsibility.

How many office, acupuncture, and/or preventive visits am I allowed each year?
If coverage is denied due to overage amount of visits, the patient will be responsible for the balance.

Do I need a referral?
Please make sure referrals are in before the time of your appointment.

Date: _____ Signature: _____