YAKIMA INTEGRATIVE HEALTH
https://www.yakimaintegrativehealth.com/
307 S 12 Ave, Ste. 9 Yakima, WA 98902
Phone: (509) 469-2483 | Fax: (509) 469-8870

PATIENT REGISTRATION

Patient Information

Name (Last, First M.I.)			Preferred name
Date of Birth	Email		Legal sex ☐ M ☐ F
Street Address	City	St	Zip
Home Phone	Cell Phone	Work Phone	
Preferred Contact: ☐ Home Phone ☐ Cell Phone ☐ Work Phone			
Do we have consent to send automated phone calls and text alerts? ☐ Phone calls only ☐ Text alerts only ☐ Both			
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Separated ☐ Widowed			
Emergency Contact Name:			Emergency Contact Phone:
Who were you referred to us by? (if applicable)			

Patient Insurance

Primary Insurance

Insurance Company Name		Co-Pay
Subscriber's ID		Group Number
Subscriber's Name		Subscriber's Employer:
Subscriber's Date of Birth	Subscriber's Sex ☐ M ☐ F	Patient's Relationship to Subscriber:

Secondary Insurance

Insurance Company Name		Co-Pay
Subscriber's ID		Group Number
Subscriber's Name		Subscriber's Employer:
Subscriber's Date of Birth	Subscriber's Sex ☐ M ☐ F	Patient's Relationship to Subscriber:

Responsible Party

Who is responsible for charges on this account? (Typically the insurance policy holder) ☐ Self ☐ Parent ☐ Guardian			
Name (Last, First M.I.)			
Street Address	City	St	Zip
Home Phone	Cell Phone	Work Phone	

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REGISTRATION AGREEMENT

I, the patient or guarantor, certify that this information 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 claims. I authorize my insurance claim to be paid directly to the clinic.

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

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Massage Health History Questionnaire

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

Name (Last, First) _____

Preferred Name _____ Date of Birth _____

Reason for Visit _____

Health Information

Are you taking any medications? ☐ Yes ☐ No

If yes, please list: _____

Any allergies? (oils, lotions, nuts, fruits, skin, etc.) ☐ Yes ☐ No

If yes, please list: _____

Are you pregnant? ☐ Yes ☐ No If yes, how many months? _____

Are you currently under medical supervision or receiving other medical interventions? ☐ Yes ☐ No

If yes, please describe: _____

Review of Symptoms

If you have experienced any of the following in the last 3 months, please checkmark:

- □ Areas of swelling
- □ Autoimmune disorder
- □ Back/neck problems
- □ Bleeding disorders
- □ Blood clots
- □ Bruise easily
- □ Bursitis
- □ Cancer
- □ Contagious condition
- □ Decreased sensation
- □ Diabetes
- □ Fibromyalgia
- □ Headaches
- □ Heart condition
- □ Hypertension
- □ Kidney disease
- □ Multiple sclerosis
- □ Neurological condition
- □ Neuropathy
- □ Osteoarthritis
- □ Osteoporosis
- □ Phlebitis
- □ Sciatica
- □ Seizures
- □ Stroke
- □ Tendinitis
- □ TMJ disorder
- □ Varicose veins
- □ Vertigo/dizziness

Do you have any areas of broken skin? (e.g. rash, wounds) ☐ Yes ☐ No If yes, where? _____

Do you have a history of joint replacement surgery? ☐ Yes ☐ No If yes, which joint? _____

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Any recent injuries or medical procedures in the past two years? ☐ Yes ☐ No

If yes, please describe _____

Please decribe any other injuries or health conditions _____

Massage Information

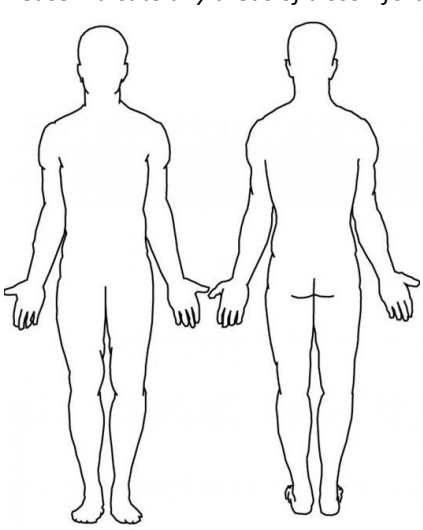
Have you had a professional massage before? ☐ Yes ☐ No

If yes, how recently? _____

Reason for seeking massage: ☐ Relaxation ☐ Problem

How much pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

Please indicate any areas of discomfort



I understand that it is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

_____ _____

Patient or Legally authorized individual signature Date Time

Patient Name: _____

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NOTICE OF PRIVACY POLICY

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 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.

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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 without 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

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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.

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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 caretakers who can have access to your medical records.)

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

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

- Cell phone confirmation
- Home phone confirmation
- Work phone confirmation
- Text message to cell phone
- Email confirmation
- Any of the above

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

- Message on cell phone
- Message on home phone
- Text message
- Email message
- Any of the above

Date: _____

_____ _____
Please print your name Please sign your name

_____ _____
Legal Representative Description of Authority

This form will be retained in your medical record.

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FINANCIAL POLICY

At Yakima Integrative Health, we understand that the medical system can result in complicated billing structures that cause stress for our patients, so we try to be completely transparent with our billing process. There are two models for billing that we use: insurance billing and direct pay. Below you will find information about both models.

INSURED PATIENTS

A list of insurances that our office can bill can be found on our website (address can be found in header). Please note that insurance benefits vary from plan to plan, and that your health insurance policy is an agreement between the Health Plan and yourself. We at Yakima Integrative Health make every effort to support billing your health insurance for your benefit, but we have found that as an integrative medical clinic, not all services will be deemed medically necessary by your health insurance carrier.

For insurances that we cannot bill or that do not cover the services provided in your treatment, we provide a transparent pricing structure at a discounted rate for direct-to-patient billing. You can find all the information necessary in the "Direct Pay Patients" section below. To know for sure whether your plan covers the cost of services provided at our clinic, please contact your insurance or visit their website to find out if the specific evaluation and procedure codes for your treatment plan are covered. Please contact the front office with any questions about the coding and billing.

If medical treatment is requested during an annual physical exam, the provider bills the insurance carrier for those services separately from the annual exam charge. Similarly, if the provider is credentialed both as an acupuncturist and naturopath and both modalities are used during the visit, the provider will bill for both services.

The amount of office or preventative visits, as well as the amount of acupuncture, massage therapy or osseous manipulation therapy visits, depends on your insurance plan. If coverage is denied due to overage of visits, you will be responsible for paying the balance. If a referral is needed per your insurance plan for coverage, please ensure the referral is submitted to your insurance before the time of your appointment.

Effective August 15, 2024, insurance patients may have an additional charge billed to their insurance. This charge helps ensure that the additional work and expertise required to manage your primary care are recognized and properly billed. If insurance does not cover this charge, *you may be billed no more than $16.04 for certain visits.*

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DIRECT PAY PATIENTS

Visits that are direct-to-patient pay are at a flat-rate that is discounted from the full rate. Visits will be billed in accordance with what is performed at the time of visits; any additional testing or procedure performed at the office will be billed separately. Superbills (invoiced lists of services) can be provided after the visit.

FINANCIAL POLICY AGREEMENT

I, _____ , a patient or legal representative of a patient of Yakima Integrative Health, 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 know 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 should I consent for them to be performed.

I understand that I am financially responsible for any and all services and procedures that are performed with my consent for treatment, should I be paying directly or my insurance or third party payer deny or provide partial benefits for the services performed.

I understand that should I be a direct pay patient, I am financially responsible for all costs. I understand that payment is due at the time of service.

I, a patient or legal representative of a patient of Yakima Integrative Health, authorize and assign you, the medical provider and treating facility, the right to receive direct payment from my attorney, insurance company or any other party who may become obligated to pay me any sums. I further authorize endorsement of my name to any draft containing my name to which you are legally entitled.

_____ _____

Signature Date

This form will be retained in your medical record.

Patient Name: _____

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OFFICE POLICY

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 – Thursday, 9:00AM to 5:00PM and Friday, 9:00AM to 3:00PM

Insurance Billing
A list of insurances that our office can bill is on our website (address in header above). We ask that you check with your insurance provider before your first appointment to confirm coverage as naturopathic, acupuncture, massage therapy, and osteopathic services vary among insurances. At this time, Medicare does not cover our services and we cannot bill Medicare or any supplemental Medicare plans.

Payment Policy
Payment is due at the time of service for **self-pay, copays, and any outstanding balances**. For your convenience, we accept exact cash, personal checks, and debit/credit cards. For coinsurance plans, we will bill your insurance first, and you will be responsible for any remaining balance after insurance processes your claim. Payment is not required at the time of service unless a prior balance exists.

Overdue Balance Policy
A **$25 late fee** will be applied to balances unpaid **60 days** after the insurance claim is processed and the patient portion is determined. Balances exceeding **$100 that remain unpaid for 90 days** will be forwarded to a collections agency.

Late Policy
To provide the best care for all patients, we require timely arrival for appointments. If you arrive more than 10 minutes late, your appointment may need to be rescheduled, and the missed appointment fee (see below) will apply. We appreciate your understanding.

Missed Appointments
If you need to reschedule your appointment, please give us 24 hours' notice. We charge $100 for any appointments missed, canceled or rescheduled in less than a 24-hour notice.

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

I, a patient of Yakima Integrative Health, have read the above policies and understand them.

Signature _____ Date _____

Patient Name: _____