Cornerstone Family Health Clinic
Patient Registration Information

Please PRINT AND complete ALL sections below…Thank You.

PERSONAL INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

Driver's License No.: _____ Issue Date: _____ / _____ / _____

Email Address: _____

INSURANCE INFORMATION

Please present insurance cards to the front desk.

PRIMARY Insurance Name: _____

Name of Policy Holder : _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Number: _____ Group No: _____

SECONDARY Insurance Name (IF APPLICABLE) _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Number: _____ Group No.: _____

EMERGENCY INFORMATION

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: ( ) Work Phone: ( ) Cell Phone: ( )

Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Cornerstone Family Health Clinic for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Patient Signature: _____

Date: _____ Parent Signature (if patient is under 18):_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been given a copy of Cornerstone Family Health Clinic's *Notice of Privacy Practices* ("Notice"), which describes how my health information is used and shared. I understand that Cornerstone Family Health Clinic has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Cornerstone Family Health Clinic.

Date: _____ Patient Signature: _____

Date: _____ Parent Signature (if patient is under 18): _____

Naturopathic Medicine
Informed Consent for Treatment

I, _____, hereby authorize Cornerstone Family Health Clinic to perform the following procedures, but not limited to, to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g., venipuncture, Pap smears, laboratory, diagnostic imaging.
Minor office procedures: e.g., cleaning, dressing a wound, ear lavage, skin scraping, skin cryotherapy, sutures.
Acupuncture: The insertion of pre-sterilized, disposable needles through the skin into the underlying tissues at specific points on the surface of the body.
Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections, intravenous nutrition.
Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, 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.
Vaccinations, 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 the staff of Cornerstone Family Health Clinic 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.

Notice of Allergies: all patients must alert the doctor if they have any known or suspected allergies (environmental, food, drug, etc.).

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Cornerstone Family Health Clinic 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

Cornerstone Family Health Clinic Financial Policy and Fees

We are honored to be a part of your health care team and we promise to provide you with the highest quality medical care. We feel that is extremely important that you have a clear understanding of our expectations regarding billing and payment. Please read and sign the following financial policy prior to your first visit. If you have any questions or would like an explanation, please feel free to ask.

1. INSURANCE: Your insurance policy is a contract between you and your insurance carrier. It is your responsibility to know what your policy covers and what it does not. If you insurance plan requires that you have a referral to see us, it is your responsibility to make sure that you have a referral on file with your insurance company before your appointment. If your insurance has naturopathic medical benefits, acupuncture and/or mental health benefits, we will gladly bill them for you. You are responsible for the co-pay, deductible and payment for non covered services as payment in full. **Co-payments MUST BE made at the time of service or there will be a $15 charge.**

_____
Initial

2. FEES: Charges and fees for your care are based on values created by the American Medical Association and is adopted by most insurance companies. Medical billing depends **upon the *complexity***, not the time spent with each patient. You are welcome to know what the charge is for any given service.

_____
Initial

3. NON-COVERED SERVICES: There are several services that Cornerstone Family Health Clinic provides for you that may or may not be covered by your insurance company. Although these services are not required for your care, they may be important for you: Some examples of non-covered services include emergency pager fees, telephone conferences and email visits. **Although these fees can vary depending upon the complexity, a typical emergency pager fee can start at $25, a telephone conference ranges between $90-$200, and an e-mail fee ranges between $25-$125.**

_____
Initial

4. PAYMENT POLICY: Payment is expected at the time of service. This includes any co-pay, fees not covered by your insurance, pharmacy fees, etc. Keep in mind that you will receive statements from Cornerstone Family Health Clinic to keep your account current. **A $5 rebilling fee** will be assessed if there is a failure to make a payment or make contact with Cornerstone Family Health Clinic. If you account is over 90 days past due, you may receive a letter stating that you have a specified amount of time to make payment arrangements. Failure to make payment arrangements will result in your account being referred to a collection agency and you may be immediately discharged from this practice. **A $5-$25 fee** will be charged to all non-sufficient funds (NSF). When a minor is seen at Cornerstone Family Health Clinic, payment is expected from whoever accompanies the minor to the visit.

_____
Initial

We send statements by email, instead of mail, please provide your email address below: Please be sure to check your junk mail folder and adjust your email settings as statements will be sent from billing@cornerstonehealthclinic.com

Valid Email address: _____ _____
Initial

5. APPOINTMENTS: A missed appointment is a loss to everyone. Please give 24 hours notice if you are unable to keep your appointment; otherwise we reserve the right to charge for the time reserved **($50-$135)**. This charge is **your responsibility**, as insurance companies do not pay for missed appointments.

_____
Initial

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

_____ _____
Signature of patient or responsible party Date signed

Cornerstone Family Health Clinic
13115 121st Way NE, Ste. C
Kirkland, WA 98034
P: (425) 821-1800 / F: (425) 821-1818

Name: _____ **Age:** _____ **Date of Birth:** _____
Nickname/preferred name: _____

List Current Health Concerns

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

Goals/Expectations: _____
_____
_____
_____

What are the most significant measures you have taken to improve your health? _____
_____
_____
_____

Have you seen a naturopath before? No Yes
Are you currently seeing one? No Yes, Doctor's name: _____
Do you currently have a medical doctor? No Yes, Doctor's name: _____
Are you currently seeing a chiropractor, acupuncturist, counselor, or any other health care professional? If so, please list:
_____
_____

List the prescribed medications, non-prescription medications, herbals, vitamins, and minerals you are currently taking:
_____
_____
_____
_____

Please list any medications you have been prescribed, but are not taking: _____
Do you have a history of allergies or reactions? No Yes (please list and include your reaction)
Medications: _____
Environmental: _____
Foods: _____
Other: _____

Please list any major illnesses, hospitalizations, surgeries (date and brief description): _____
_____
_____
_____

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Name: _____

Height: _____
Weight: _____ Weight 1 year ago: _____ Max weight: _____

Personal and Family History:
Please indicate if you or a family member has experienced the following health complaints

Unknown

AIDS/ HIV _____
Alcoholism _____
Allergies _____
Anemia _____
Arthritis _____
Asthma _____
Cancer _____
Depression _____
Diabetes _____
Drug Problems _____
Excema _____
Gout _____
Heart Disease _____
High Blood Pressure _____
Hypoglycemia _____
Kidney Disorder _____
Mental Illness _____
Migraines _____
Obesity _____
Psoriasis _____
Senility _____
Sexual Abuse _____
Seizures _____
Stroke _____
Suicide _____
TB _____
Thyroid Disorder _____
Ulcer _____
High Cholesterol _____

Review of Symptoms:
Circle Yes if experience within the last 1 month

Constitutional _____			**Endocrine** _____		
Good Recent Health	Yes	No	Excessive thirst/urination	Yes	No
Recent Weight Change	Yes	No	Hair loss or unusual growth	Yes	No
Night sweats, Fever	Yes	No	Cold hands/feet	Yes	No
Fatigue	Yes	No	Hormone Problems	Yes	No
Cardiovascular _____			**Urinary** _____		
Chest pain	Yes	No	Blood in urine	Yes	No
Palpitations	Yes	No	Pain/ Burning w/ urination	Yes	No
Heart Trouble	Yes	No	Kidney Stones	Yes	No
Swelling hands/ feet	Yes	No	Recurrent Bladder Infections	Yes	No
Lightheaded/ dizziness	Yes	No	Difficulty with voiding	Yes	No

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Name: _____

Musculoskeletal _____			**Ears/Nose/Throat/Mouth _____**		
Muscle pain/cramps	Yes	No	Hearing loss or ringing	Yes	No
Stiffness/Swelling Joints	Yes	No	Sinus problems	Yes	No
Trouble walking	Yes	No	Sore throat/voice change	Yes	No
Respiratory_____			**Neurological_____**		
Shortness of Breath	Yes	No	Frequent Headaches	Yes	No
Cough	Yes	No	Paralysis or Tremors	Yes	No
Wheezing/Asthma	Yes	No	Seizures	Yes	No
Difficulty Breathing	Yes	No	Numbness or Tingling	Yes	No
Sleep Apnea	Yes	No			
Skin_____			**Male/Female_____**		
Rashes or itching	Yes	No	Menstrual Problems	Yes	No
Abnormal Nails	Yes	No	Sexual Problems	Yes	No
Dry Skin	Yes	No	Testicle/Ovary Pain	Yes	No
Discolored Skin	Yes	No	Infertility	Yes	No
Body Odor/ Excessive Sweat	Yes	No	Breast Concerns (lumps, discharge/ pain)	Yes	No
Eyes_____			**Hemotologic/Lymphatic_____**		
Wear glasses/contacts	Yes	No	Anemia	Yes	No
Blurred/double vision	Yes	No	Bruise Easily	Yes	No
Eye Disease/Injury	Yes	No	Slow to Heal	Yes	No
Eye Pain	Yes	No	Enlarged Glands	Yes	No
Allergies_____			**Psychiatric_____**		
Food Allergies	Yes	No	Depression	Yes	No
Hay Fever	Yes	No	Anxiety/Panic Attacks	Yes	No
Chemical Sensitivity	Yes	No	Confusion/Memory Loss	Yes	No
			Insomnia	Yes	No
			Suicidal Ideation	Yes	No

Digestion_____					
Indigestion/Belching/Reflux	Yes	No	Abdominal Pain	Yes	No
Nausea/Vomiting	Yes	No	Hemorrhoids	Yes	No
Early Fullness	Yes	No	Rectal Bleeding	Yes	No
Gas/Bloat	Yes	No	Mucous in Stool	Yes	No
Diarrhea	Yes	No	Abnormal Stool Color	Yes	No
Constipation	Yes	No			

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Name: _____

Women:
Last menses start date: _____ Regular cycle Irregular cycle
Painful menses? Yes No
Premenstrual complaints? Yes No If yes, list: _____
Are you planning to conceive now or in the near future? Yes No
If sexually active, what form of birth control do you use? _____

Lifestyle

Stressors: Rate level of stress, (10 = high stress, 1 = low stress): _____
Top stressor currently or in recent past, if any: _____

Exercise:
Do you exercise regularly? Yes No
Regimen: _____
Frequency/Duration: _____
How long have you been on this program? _____

Diet:
Do you eat breakfast? Yes No Time: _____
Describe typical meal: _____
Do you eat lunch? Yes No Time: _____
Describe typical meal: _____
Do you eat dinner? Yes No Time: _____
Describe typical meal: _____
Do you snack? Typical snacks: _____
What are your food cravings, or attractions? _____
Coffee: _____cups/day Caffeinated Tea: _____cups/day Chocolate_____/day
Water Intake: _____glasses/day
Are there any foods that disagree with you/or that you avoid (meats, etc)? _____
_____

Habits:
Do you smoke or chew (tobacco)? Yes No _____packs/day or amount/day
Do you drink alcoholic beverages? Yes No _____drinks per: day week month
Other: _____

Sleep:
Rate the quality of sleep (10 is good, 1 is poor): _____
Anything else you want the doctor to know: _____

□ Reviewed with patient _____

Cornerstone Family Health Clinic

Notice of Privacy Practices

We respect our legal obligation to keep health information that identifies you private. As obligated by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We do not use your health information in our office or disclose it outside of our office without your written permission. In some limited situations, the law requires us to disclose your health information without either written or verbal consent.

We will ask you to sign a consent form allowing us to use and disclose your health information for purposes of treatment, payment, and healthcare operations in this office. We are allowed to refuse to treat you if you do not sign the consent form.

We are permitted to use and disclose your healthcare records for the purpose of treatment, payment, and healthcare operations:

- Treatment means providing coordination, or managing healthcare related services by one or more healthcare providers. For example, we may need to share information with other providers or specialists involved in your care.
- Payment means activities as obtaining reimbursement for services, verifying coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a medical plan for you.
- Healthcare operations include the business aspects of running our practice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization or as permitted by law.

In some limited situations, the law requires us to use and disclose your health information without your permission. These examples may never come up at our office at all, but such disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose.
- For public health purposes, such as contagious disease reporting and notices to and from the FDA regarding drugs and medical devices.
- Disclosure to government authorities about victims of suspected abuse, neglect, or domestic violence.
- Uses and disclosures for health oversight activities, such as for the audits by your insurance plan, or for investigation of possible violation of healthcare laws.
- Disclosures in response to subpoenas or orders of the court.
- Disclosures for law enforcement purposes, such as to provide information about someone who is suspected to be a victim of a crime, or to provide information about a crime at our office.
- Disclosure related to worker's compensation programs.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information to any person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to ask us to communicate to you in a confidential way, such as by phoning you at work rather than at home or by mailing health information to a different address. Please provide a written request.
- The right to ask to see or to get photocopies of your health information. You may have to pay for photocopies in advance. We do charge a fee to release your records to an outside source other than a healthcare provider (examples are lawyers, healthcare research firm, etc). Please complete our written records request for billing or medical record release.
- The right to receive an accounting of disclosures of protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice from us upon request.

This notice is originally effective March 17, 2003 and revised on January 1, 2007. We are required to abide by the terms of this Notice of Privacy Practices and to make the new notice provisions effective for all protected healthcare information that we maintain. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel that your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our privacy practices:
Cornerstone Family Health Clinic
13115 NE 121st Way NE
Suite C
Kirkland, WA 98034
425.821.1800

For more information on HIPAA or to file a complaint:
The US Dept. of Health & Human Services
Office of Civil Rights
200 Independence Ave. SW
Washington DC, 20201
877.696.6775