

Whole Health Naturopathy

Marnie Frisch ND & Savahn Rosinbum ND
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REGISTRATION FORM

(Please Print)

Today's date		PCP				
PATIENT INFORMATION						
Patient's Legal Last Name		Legal First	Middle initial	Preferred Name	Age	Birth Date / /
Former name, if any	Marital Status	Social Security Number		Gender	Legal Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Street address		E-mail Address			Home phone ()	
City	State		ZIP Code	Cell phone ()		
Occupation	Employer			Work phone ()		
At which of these phone numbers can we leave a detailed message?						
Chose clinic because/was referred to clinic by						
Other family members seen here						
INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.) It is your responsibility to contact your insurance company to verify coverage for Naturopathic physicians and services. Your policy may not cover claims made by this office, which will leave you responsible for the charges.						
Person responsible for bill		Address (if different)		Home phone ()		
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Birth / /				
Occupation	Employer	Employer address		Employer phone ()		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Referral needed from PCP?				
Name of primary insurance		Group number	ID number	Co-payment amount		
Subscriber's name		Subscriber's Social Security Number		Birth date		
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						
Name of secondary insurance (if applicable)		Subscriber's name	Group #	Policy #		
Patient's relationship to subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						
IN CASE OF EMERGENCY						
Name of local friend or relative (not living at same address)		Relationship to patient	Home phone ()	Work phone ()		
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Whole Health Naturopathy or insurance company to release any information required to process my claims.						
Patient/Guardian signature				Date		

Whole Health Naturopathy

Marnie Frisch ND & Savahn Rosinbum ND

Financial Policy

Health insurance is a contract between the patient and their insurance carrier. The insurance policy lists a package of medical benefits such as treatment services, tests, office visits and therapies. The insurance company agrees to cover the cost of certain benefits listed in your policy. These are your covered services.

Your policy also lists the kinds of services that are not covered by your insurance company. These are your exclusions. You must pay for any uncovered medical care that you receive. Keep in mind that a medical necessity is not the same as a medical benefit. A medical necessity is something that your doctor has decided is necessary. A medical benefit is something that your insurance plan has agreed to cover. In some cases, your doctor might decide that you need medical care that is not covered by your insurance policy. Insurance companies determine what tests, therapies and services they will cover. Your insurance company's choices may mean that the test, therapy or service you need isn't covered by your policy.

By understanding your insurance coverage, you can help your doctor recommend care that is covered in your plan. Whole Health Naturopathy will try to be familiar with your insurance coverage so we can provide you with covered care. However, there are so many different insurance plans that it's not possible for your doctor or our staff to know the specific details of each plan.

- Take the time to read your insurance policy. It's better to know what your insurance company will pay for before you receive a service, get tested or fill a prescription. Some kinds of care may have to be approved by your insurance company before your doctor can provide them.
- If you still have questions about your coverage, call your insurance company and ask a representative to explain it.
- Your insurance company, not your doctor, makes decisions about what will be paid and what will not.
- Your physician, not your insurance company, makes medical decisions and recommendations about what will benefit your health.

Some services, tests or therapies recommended by your provider may not be covered by your insurance policy. When you have a test or treatment that isn't covered, your insurance company won't pay the bill. You can still obtain the treatment your doctor recommended, but you will have to pay for it yourself. Claims may not be resubmitted with different codes if they have been denied for lack of coverage.

Preventive office visits

Well-child exams, annual gynecological exams, and routine physicals are coded differently from standard office visits, and are based on the age of the patient and whether you are a new or established patient. Your preventive benefits only cover services provided in the absence of illness or complaints. Legally we are not permitted to resubmit claims with a new diagnosis or procedure code if the claim was accurately submitted as a non-preventive visit and covered differently by your insurance company. If there are additional concerns brought up at these preventive office visits, there will be an additional brief office visit fee.

Billing:

If you receive a bill from us, it is because we believe the balance is your responsibility. Please contact your insurance company first, if you think there is a problem. If you have any questions about your bill, please call our billing department immediately. If you cannot pay your entire balance, please call to make payment arrangements.

Please note: Labs and other ancillary services – i.e. testing, medical imaging, etc. are not part of our practice. Please call the number(s) listed on those statements for assistance.

It is the policy of Whole Health Naturopathy to collect all payments or insurance information at the time services are rendered. For your convenience, we accept cash, check, Visa or MasterCard.

We will submit your insurance claims directly to any insurance your provider is contracted with, provided the information we have obtained from you is accurate and complete, however the patient assumes responsibility for all unpaid balances, co-payments, and deductibles due, as well as any non-covered service by the insurance company, including cost of collection. It is the patient's responsibility to provide the most current insurance information to our office at the time services are rendered. A rebilling charge of **\$5.00** will be added if claims need to be resubmitted to the correct insurance company.

It is your responsibility to know the limits and exclusions to your insurance coverage.

AUTOMOBILE ACCIDENT PATIENTS: We do treat automobile accident patients. However, we are unable to monitor long-term accounts and we will not accept a letter of protection from an attorney as a guarantee of payment or third party insurance payments.

SELF-PAY PATIENTS: If you have no insurance coverage for our services, we offer a discount on office visits and procedures. Payment in full is due at the time of service. We are unable to extend a payment plan on our self-pay rates.

NSF: All checks returned for non-sufficient funds will result in a **\$50.00** service charge to be collected at the next visit, or within 30 days (whichever comes first).

UNPAID STATEMENTS: A **\$5.00** rebilling fee will be charged each month on any outstanding balances. If no payment is received on an account after 90 days, the account will be sent to the collection agency. Should the account be referred for collections, the undersigned, or their agent, will be responsible for payment of interest on the unpaid balance at 1% per month from the date of service, collection fees, reasonable attorney fees and court costs.

By accepting this form:

- I understand and agree that my health insurance is an arrangement between my insurance carrier and myself; that all services furnished to me are charged directly to me and that I am personally responsible for payment of all services.
- I authorize treatment and agree to pay all charges. Charges shown on statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing.
- It is agreed that payment will not be delayed or withheld because of any insurance coverage or pendency of the claims thereon.
- I agree to pay for any missed appointments that were not canceled or rescheduled at least 24 hours in advance. **I am aware of and will pay a \$40.00 late cancellation fee if my appointment is cancelled less than 24 hours from the time of my scheduled appointment.**

Whole Health Naturopathy firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or need clarification regarding these policies please call us at (360) 943-9519.

Signature _____ Date _____

Print Name _____

Insurance Verification and Benefits

We are contracted with most major insurance companies; your insurance company can verify your provider's status when you call. Please be aware though that specific policies vary in their coverage of naturopathic medicine regardless of the provider's network status.

Whole Health Naturopathy will try to be familiar with your insurance coverage so we can provide you with covered care. However, there are so many different insurance plans that it's not possible for your doctor or our staff to know the specific details of each plan and cannot be responsible for benefit determination.

It is important to verify your coverage prior to your first appointment.

Here are some important questions to ask when calling to verify your benefits. Please bring this completed form to your first appointment.

Patient Name _____ DOB _____

Subscriber's Name _____ DOB _____

Insurance ID # _____

Date called _____ Insurance Rep's name _____

Provider (Marnie Frisch and/or Savahn Rosinbum) are they in my network? **YES NO**

Does my plan cover services performed by a Naturopathic Physician (ND)? YES NO

Do I have any exclusions to naturopathic services? _____

What is my copay amount? _____

What is my coinsurance amount? (The % of each visit you are responsible for) _____

What is my yearly deductible _____

Has my deductible been met for the year? **YES NO** If no, how much is remaining? _____

Is there a limit on the number of ND visits per year? **YES NO** What is the limit? _____

Do I need a referral/pre-Authorization from my PCP for ND services to be covered? _____

What are my preventive office benefits? _____

Have my preventive office benefits been met this year? **YES NO**

If yes, when do they renew? _____

What are my **Physical Therapy Benefits**? (Cranial Sacral therapy, code 97140)

Do I need a Pre-Authorization for Physical Therapy? **YES NO**

Are there exclusions? _____

There are no guarantees of these benefits and your insurance company makes final determination of payment when the actual claim is received. Any benefit level appeals must be made by the patient.

Whole Health Naturopathy

Marnie Frisch ND & Savahn Rosinbum ND

PATIENT PROFILE

Legal Last Name: _____ Legal First Name: _____ Preferred Name: _____

Birthdate: _____ Gender: _____ Legal Sex: F M

Present Health Concerns

Please list most important health concerns in their order of significance.	Prior diagnosis of this problem? If so, what?
1.	
2.	
3.	
4.	
5.	

What goals do you have for your visit today? _____

Have you ever consulted a Naturopathic physician, an Acupuncturist, a Nutritionist or a Counselor before? (circle)

Do you have any questions about this visit or the care that you've chosen today?

Please list prescription medications that you are currently taking, with dosages:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Preferred Pharmacy: _____ Refills needed today? _____

Please list vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Please list any severe or life-threatening allergies and your reactions: _____

PAST MEDICAL HISTORY

Hospitalizations, Serious Illnesses and Injuries: _____

Date of last physical/annual exam: _____ Date of last blood tests: _____

Any abnormal results? _____

PERSONAL AND FAMILY MEDICAL HISTORY:

For grandparents, use P for paternal, M for maternal i.e. PGM = paternal grandmother

Check those that apply:	Yourself	Mother	Father	Grand parents	Sister/ Brother	Spouse	Children
Addictions (type)							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Bleeding Disorder							
Cancer (what type?)							
COPD / Emphysema							
Depression							
Diabetes							
Eczema							
Epilepsy							
Heart Disease							
Hepatitis							
High Blood Pressure							
High Cholesterol							
HIV / AIDS							
IBS							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraines/Headaches							
Stroke							
Thyroid disorder							
Tuberculosis							
Ulcers							
Other							

SOCIAL HISTORY:

Please circle those that apply: Single Married Partnered Significant other Polyamorous
 Do you have any children? yes no Please list their age(s) _____

SLEEP: Do you -

Sleep through the night? yes no | Have trouble falling asleep? yes no | Wake refreshed? yes no

STRESS & MOOD:

How well have things been going for you?	Very well	Fine	Poorly	Doesn't apply								
Overall												
At school												
In your job												
In your social life												
With close friends												
With sex												
With your attitude												
With your significant other/s (spouse, date, etc)												
With your children												
With your parents												
With your spouse												
Recent stress level on a 0-10 scale (10 highest):	0	1	2	3	4	5	6	7	8	9	10	10+

What helps you de-stress? _____

What activities bring you joy? _____

PHYSICAL ACTIVITY:

Rate your motivation to exercise: low medium high | Do you exercise regularly? yes no

What type? _____ How long? _____ How often? _____

ENVIRONMENT:

Current Occupation _____

Known exposure to volatile chemicals, heavy metals, pesticides _____

Ever lived near factories, incinerators, railroads, farms, golf courses or known hazardous chemical dumps? _____

Are you sensitive to smells? _____ Is there mold in your home? _____

Do you feel safe in your home? _____

LIFESTYLE:

<i>Circle what you use regularly.</i>	Coffee/black tea/soda	Alcohol	Tobacco	Marijuana	Recreational drugs
Type					
How much?					
How often?					
Are you or others concerned about use?					

Have you ever been a regular tobacco smoker? yes no If you've quit, when was that? _____

NUTRITION:

Do you follow any particular diet regimens or restrictions? If yes, please describe: _____

Do you have any food cravings? If yes, what? _____

Any foods you react adversely to? What is your reaction? _____

Please rate your level of motivation for making any changes to your diet: low medium high

	Food on an easy weekday	Food on a challenging weekday	Typical Weekend
Breakfast Time:			
Lunch Time:			
Dinner Time:			
Snack Time:			

Anything else you would like to add about your health?

What do you need to do to be healthier?

What are the obstacles to doing so?

Thank you for taking the time to fill out this form. It will help me help you.

Consent for Treatment

I hereby authorize Dr. Marnie Frisch & Dr. Savahn Rosinbum, naturopathic doctors to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

General Diagnostic Procedures (including but not limited to venipuncture, pap smears, radiography, and blood and urine labwork, general physical exams, neurological and musculoskeletal assessments)

Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions

Herbs/Natural Medicines (prescribing of various therapeutic substance including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical creams, pastes, plasters washes; suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, 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 or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy)

Electromagnetic and Thermal Therapies (includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and 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 needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and 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. Labor-stimulating techniques or any labor-inducing substances will not be used 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. Marnie Frisch and Dr. Savahn Rosinbum. 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 me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

Guardian/Personal Representative's Name (PRINT)

Patient's Name (PRINT)

Guardian/Personal Representative's Signature

Patient's Signature

Relationship/Representative's Authority

Date

Date

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Dr. Marnie Frisch & Dr. Savahn Rosinbum of Whole Health Naturopathy to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by Whole Health Naturopathy describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Dr. Frisch & Dr. Rosinbum reserve the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Whole Health Naturopathy at the above address.

With this consent, Dr. Frisch & Dr. Rosinbum may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Dr. Frisch & Dr. Rosinbum may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Dr. Frisch & Dr. Rosinbum may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Marnie Frisch restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Dr. Frisch & Dr. Rosinbum to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Frisch & Dr. Rosinbum may decline to provide treatment to me.

Print Name of Patient or Legal guardian

Signature of Patient or Legal Guardian

Date

Notice of Privacy Practices Acknowledgement

This form is used to ensure that you have had the opportunity to read and review the health care practitioner's Notice of Privacy Practices which are available on the website www.olympianaturopath.com and in the Whole Health Naturopathy office.

The Notice of Privacy Practices describes how medical information about you may be used and disclosed, how you can get access to this information and who to contact if you have questions, concerns, or complaints.

Health care practitioners have a responsibility to protect the privacy of your information. You are entitled to receive their Notice of Privacy Practices that describes the health information privacy practices that have been put in place to protect your privacy.

If you have any questions, contact the privacy officer identified in the Notice of Privacy Practices.

Any significant change in these privacy practices will be posted. You may request a copy of the Notice of Privacy Practices at any time by contacting your practitioner or the privacy officer.

You may request a copy of this signed acknowledgement.

By signing below, I agree that I have received the Notice of Privacy Practices.

(Signature of patient or legally authorized person)

Date

(Printed Name if not the patient)

(Relationship to Patient)

For Office Use Only (ver. 16.1) Date Received: _____

File Reference #: _____ Action: _____

Person acting: _____ Response Date : _____ Filed

Without Response