Whole Health Naturopathy

Marnie Frisch ND & Savahn Rosinbum ND
2600 Martin Way E, Suite B / Olympia, WA 98506
360-943-9519 F: 360-943-9534

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
				❑ M ❑ 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? ❑ Yes ❑ No	Date of Birth / /	

Occupation	Employer	Employer address	Employer phone
			( )

Is this patient covered by insurance? ❑ Yes ❑ 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: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable)	Subscriber's name	Group #	Policy #

Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ 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.

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PEDIATRIC/ADOLESCENT HEALTH HISTORY INTAKE FORM

Last Name:_____First Name:_____

Preferred Name: _____Middle Name:_____

Date of Birth:_____Age:_____Birth Sex:_____Gender:_____

PRENATAL/BIRTH HISTORY

A. Pregnancy: ☐Normal ☐Complications:_____
B. Gestation:_____weeks
C. Birth Location: ☐Hospital ☐Birthing Center ☐Home ☐Other_____
D. Delivery: ☐Vaginal ☐C-Section…..Any Complications: ☐No ☐Yes_____
E. Birth Weight:_____lbs_____oz…..Length:_____inches

PRESENT HEALTH CONCERNS: Please list most important health concerns in their order of significance

1._____

2._____

3._____

4._____

Are you seeking ☐adjunctive care or ☐primary care? Is today's visit a Well Child visit? ☐yes ☐no

PAST MEDICAL HISTORY

MEDICATIONS: Please list prescription medications +/or over the counter medications that you are currently taking, with dosages

1._____ 2._____3. _____

4. _____5. _____6. _____

SUPPLEMENTS: Please list vitamins, minerals, herbs, & homeopathics that you are currently taking, with dosages

1._____ 2._____3. _____

4. _____5. _____6. _____

ALLERGIES: Please include mild to severe or life-threatening allergies and reaction (symptoms)

1. Medications_____

2. Environment_____

3. Food_____

PAST MEDICAL HISTORY

CHILDHOOD ILLNESSES (Circle and indicate age of illness OR mark C for current as it applies to your child)

Acne:	No	Yes/Age_____	Ear Infections:	No	Yes/How often:_____
ADD:	No	Yes/Age_____	Eating Disorders:	No	Yes/Age and type:___
ADHD:	No	Yes/Age_____	Eczema:	No	Yes/Age:_____
Alcohol use:	No	Yes/How often:_____	Head lice:	No	Yes/Age:_____
Allergies:	No	Yes/Age_____	Molluscum contagiosum:	No	Yes/Age:_____
Asthma:	No	Yes/Age_____	Mononucleosis:	No	Yes/Age:_____
Bedwetting:	No	Yes/Age_____	Obesity/Overweight:	No	Yes/Age:_____
Behavior problems:	No	Yes/Age_____	Pink eye:	No	Yes/Age:_____
Bronchitis:	No	Yes/Age_____	Pneumonia:	No	Yes/Age:_____
Colic:	No	Yes/Age_____	Colds:	No	Yes/How often:_____
Constipation:	No	Yes/How often:_____	Sinus Infection:	No	Yes/How often:_____
Cough:	No	Yes/How often:_____	Thrush:	No	Yes/Age:_____
Croup:	No	Yes/Age_____	Vomiting:	No	Yes/Age:_____
Depression	No	Yes/Age_____	Whooping cough:	No	Yes/Age:_____
Diaper rash:	No	Yes/How often:_____	Other: Age:_____		Illness:_____
Diarrhea:	No	Yes/How often:_____	Other: Age:_____		Illness:_____

IMMUNIZATIONS (Please place an **X** in either the Yes or No box next to each vaccination that you have been vaccinated against. If Yes, please indicate whether there were any reactions and describe in detail)

	No	Yes	Reaction Description
Hepatitis B			
Diphtheria, Tetanus, Pertussis			
Haemophilus Influenza Type B			
Inactivated Polio			
Measles, Mumps, Rubella			
Varicella (Chickenpox)			
Pneumococcal			
Influenza			
Rotavirus			
Human Papilloma Virus (HPV)			

SERIOUS INJURIES AND/OR ACCIDENTS: (Please indicate type, date and treatment used.)

Type Date Treatment

_____

_____

HOSPITALIZATIONS/SURGERIES: (Please indicate reason and date.)

Reason for Hospitalization Date

_____ _____

_____ _____

_____ _____

LABS AND EXAM HISTORY: (Please indicate date and results.)

Date of last well child check_____ Results ☐ Normal ☐ Other

Date of last blood work_____ Results ☐ Normal ☐ Other

Date of last urine test_____ Results ☐ Normal ☐ Other

FAMILY HISTORY: Please place a "C" for current or "P" for past in the box next to each condition as it applies

to you or your family members.

	Self	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcoholism									
Allergies									
Anemia									
Arthritis									
Asthma									
Cancer									
Depression									
Developmental Delay									
Diabetes									
Drug Addiction									
Eczema									
Epilepsy									
Headaches									
Heart Disease									
Hepatitis									
Hypertension									
Kidney Disease									
Mental Illness									
Seizures									
Stroke									
Tuberculosis									
Other (specify)									

SOCIAL HISTORY

Have you or your parents ever consulted with a Naturopathic Physician before? ☐ Yes ☐ No

Who comprises your family?

_____

Siblings (Indicate names and ages)

Parental Occupations:_____

Daycare Location:_____ Days/Hours per week:_____

TRAVEL HISTORY: Identify any domestic or foreign travel and indicate year of travel:

Place:_____ Year:_____

Place:_____Year:_____

Place:_____Year:_____

SLEEP:

How many hours of sleep do you get at night on average?_____

Toddlers/Adolescents:

How often do you wake and for what reasons?_____

Do you have any trouble falling asleep? ☐ No ☐ Yes/Why?_____

Do you have trouble waking up? ☐ No ☐ Yes/Why_____

Do you wake rested? ☐ Yes ☐ No/Why _____

SOCIAL HISTORY-Con't

NUTRITIONAL HISTORY
Infant/Toddlers:
Type: ☐Nursing ☐Formula/Specify_____ ☐Both
Duration: ☐<15 min ☐15-30 min ☐30-45 min ☐45-60 min
Frequency: ☐Every hour ☐Every other hour ☐Every 3rd hour ☐Every 4th hour ☐Every 5th hour ☐Other_____
Amount per feeding: ☐<1oz ☐1-2oz ☐2-3oz ☐3-4oz ☐>4oz

Adolescents:
What is a typical breakfast?_____
What is a typical lunch?_____
What is a typical dinner?_____
What are typical snacks?_____
How many glasses of water do you drink each day on average?_____
Do you have any special dietary restrictions?_____

EXERCISE:
Toddlers/Adolescents:
Do you exercise regularly? ☐ Yes ☐ No
If you checked yes to exercising regularly, answer the following questions:
What type/activity?_____
How long?_____ How often?_____

ENERGY AND STRESS:
Adolescents:
How would you rate your energy on a scale of 1 – 10 with 10 being the most energy?_____
How would you rate your stress on a scale of 1 – 10 with 10 being the most stress?_____
How do you cope with stress?_____

PERSONAL HABITS:
Identify any substances you have used and circle whether in the past (P) or are currently using (C)
Adolescents:
Which of the following substances do you use and identify frequency (Ex. 2x/d, 1x/mo, 1x/yr)?
☐ Tobacco: P C Freq:_____ ☐Recreational Drugs: P C Type/Freq:_____
☐ Alcohol: P C Freq:_____ ☐Other: P C Specify/Freq:_____
☐ Coffee: P C Freq:_____

Adolescents:
BIRTH CONTROL:
What form of contraception/birth control are you using (Check all that apply).
☐ Abstinence ☐ Withdrawal ☐ Fertility Awareness Method ☐ The Sponge ☐ Spermicide ☐ Condom ☐ Diaphragm ☐ Cervical Cap ☐ IUD ☐ The Pill ☐ The Shot (Depo-Provera) ☐ The Ring ☐ Implants ☐ The Patch ☐ Vasectomy ☐ None

What does your child (or your family) need to do to be healthier?

Anything else we didn't ask about?

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