ground floor health
NATURAL MEDICINE

INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize the naturopathic physicians of Ground Floor Health, PLLC to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g. venipuncture, Pap smears, radiography, laboratory, x-ray.
Minor office procedures: e.g. cleaning, suturing, and dressing a wound, ear lavage, skin scraping, skin cryotherapy.
Medicinal use of nutrition: e.g. therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.
Botanical medicine: e.g. botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, 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.
Physical medicine: e.g. massage, hot and cold therapy, stretching, manipulation, electrical muscle stimulation, and therapeutic ultrasound.
Psychological Counseling
Contraception
Vaccination

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 natural 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 Ground Floor 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.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Ground Floor Health, PLLC, or any of its 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

Original: Chart
Copy: To patient (if requested)

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Financial Policy

Thank you for choosing the physicians at Ground Floor Health to be your healthcare providers. We will do our best to provide you with the highest quality medical services. We feel that it is very important that our patients have a clear understanding of our expectations regarding billing and payment. Please read and sign the following financial policy prior to your treatment. Should you have any questions, feel free to ask.

Insurance Billing:
Ground Floor Health is contracted with most major insurance companies. You are welcome to ask for a list or if we are contracted with your specific company. For patients with these insurance plans, we bill insurance directly and accept payment plus any co-payments, co-insurance, deductibles and payments for non-covered services as payment in full. Although we are contracted with your insurance company, it does not guarantee that your plan covers all visits. **Patients are responsible to know the terms of their insurance and whether naturopathic, midwifery, and acupuncture services are covered.**

Office Fees:

- Fees are determined after the visit has taken place and depend on the complexity of the health concern, which procedures were performed, and the amount of time spent with the patient.
- If we are not contracted with your insurance company or you do not have medical insurance, we offer an income-based time of service discount. If you are having financial difficulty, we will be happy to work with you. You may want to establish a payment plan. We ask that these payments be made on time monthly and be paid in full within six months.
- 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 a naturopath and both modalities are used during the visit, my provider will bill both visits separately.

Payment Policy

- Full payment for visit co-pays, supplements and lab fees must be rendered at time of service and can be made by cash, check, Visa or MasterCard.
- Patients will be held responsible for non-payment by their insurance company. Accounts unpaid by the insurance company greater than 90 days will be billed to the patient.
- A late fee will be assessed beginning with the second billing statement if there is failure to make payment or make contact with us in 30 days. If there is no response to these actions, further action may be taken.
- If you pay for services by check and that check is returned for non-sufficient funds, we will charge an additional $40 to your account. If that happens, you will be asked to remit the amount of the check plus the service charge in cash within 10 days. If your account has not cleared by then, we may take further action.
- Showing up for your scheduled appointment is very important. If you are unable to make your appointment, please give our office 24 hours notice so that we may give another patient that time. **Patients that "no show" or do not cancel 24 hours prior to their appointment may be assessed an appointment charge of $25.** This charge is your responsibility. Insurance companies do not pay for missed appointments.

I, _____agree to the above-defined financial policies of Ground Floor Health. I give permission for the release of information requested by my insurance company to assist in processing my insurance claims. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that I'm fully responsible for the total payment of all services and procedures performed in this office. This includes any service that may not be covered by my medical insurance. In the case of default of payment, I am responsible for full payment of the balance, interest accrued, and any collection costs or legal fees incurred to collect on this account.

I, the undersigned, have read, understand, and agree to the information and conditions specified in this document.

_____
_____

Patient/Guardian Name and Signature Date

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Patient Intake Form

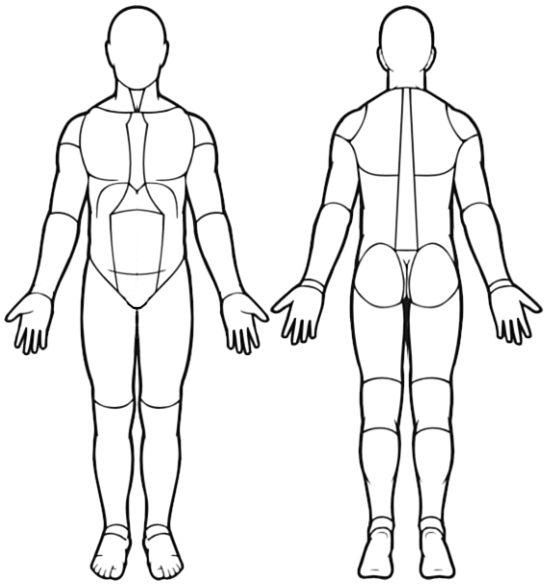
Date: _____

Last Name: _____ First Name: _____ M. I. _____

Nickname(s): _____ Birth date: _____ Sex: _____

A note to our patients: Please complete this two-sided form as thoroughly as possible to aid in your diagnosis and treatment. This is a confidential record and will not be released, except when you have provided us with written authorization to do so. Thank you.

PRESENT HEALTH CONCERNS

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

What goals do you have for your visit at the clinic today? _____

_____

Do you have any questions about our clinic or care? _____

_____

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

_____

Please list over-the-counter medications that you are currently taking with dosages: _____

_____

Please list all supplements (vitamins, minerals, herbs, homeopathic remedies) that you are currently taking with dosages: _____

_____

_____

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Please list any drug allergies, and severe or life-threatening allergies: _____

_____

Personal habits:
Please circle any of the following substances that you use regularly:

Tobacco Alcohol Coffee/black tea/cola Recreational Drugs

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

_____

Do you exercise regularly? Yes No What type? _____

How long? _____ How often? _____

What are the top stresses in your life currently? _____

_____

Past history:

Hospitalizations: _____

Serious Illnesses and Injuries: _____

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

Personal and Family History:
Please check the 'yes' box next to each condition that applies to you or one of your family members. Please note whether the condition is in the past or currently by denoting a 'P' for past, or 'C" for current. Indicate who had the condition in the 'Relation' column.

	YES	RELATION	DATE RESOLVED Past (P)/Current(C)		YES	RELATION	DATE RESOLVED Past (P)/Current(C)
Alcoholism/Drug Addiction				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema				Other			
Epilepsy							

Social History:
Please circle those that apply: Single Married Significant other

Do you have any children? Yes No Please list their age(s): _____

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Patient Information Form

Last Name:_____ First Name:_____ M.I. ____ Today's Date:_____

Other names or nicknames your records may be kept under:_____

Address:_____ Apartment #:_____

City: _____ State: _____ Zip code:_____ Country: _____ Sex: _____

Occupation: _____ Employer/School: _____

Phone: (___) _____ Work Phone: (___) _____ ext:_____ Date of Birth: _____

Social Security #: _____ Will you be applying for our reduced rate if not insured? Yes No

Parent/Gaurdian Name (minors only) _____ Parent/Guardian Name (minors only) _____

Emergency Contact: _____ Contact's Phone #: (___) _____

Are you hearing impaired? Y N Are you visually impaired? Y N Do you need an interpreter or TTY line? Y N

Do you have non-English language needs?: _____ (or) Special needs?: _____

How did you hear about us? _____

Insurance Information
Please notify us if processing Labor and Industry (L & I) or Personal Injury Protection (PIP) Claims
Please complete this section if we will be billing your insurance.

1. Does your insurance have alternative medicine benefits? Yes No

Who is your primary care provider (PCP)?: Dr. _____ Phone #: (___) _____

Clinic address: _____ City: _____ State: _____ Zip Code: _____

Does your plan require you to have a referral from your PCP to receive coverage? Yes* No

*If yes, to which physician were you referred at our clinic?: _____

2. Primary Insurance Company & Plan Name: _____

ID Number: _____ Group/Policy Number: _____

Name of policy holder: _____ Policy holder's date of birth: _____

Relationship to policy holder: _____Is your primary a: (circle) POS PPO EPO HMO

3. Secondary Insurance Company & Plan Name: _____

ID Number: _____ Group/Policy Number: _____

Name of policy holder: _____ Policy holder's date of birth: _____

Relationship to policy holder: _____Is your secondary insurance a: (circle) POS PPO EPO HMO

I, the undersigned, pledge that the above information is accurate and complete to the best of my knowledge. I understand that payment is due at the time of service for all visits at the clinic unless prior arrangements have been made. I understand that if I am providing insurance billing information, I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize Ground Floor Health, PLLC to release all information necessary to secure the payment of insurance benefits, and I authorize the use of this signature on all my insurance submissions.

X_____ _____ X_____ _____

Signature of patient* date Signature of guardian date

Relationship to patient: _____

* Guardian's signature required for minors.