205 Clark Place SE, Tumwater, WA 98501
www.heartofwellness.org
(360) 570-0401

Dear Patient:

Welcome to Heart of Wellness! We greatly appreciate you printing these forms and completing them prior to your appointment. **Please value the time reserved for you by being punctual so you can benefit fully from your appointment.** Our clinic's focus on *the whole you - physical, emotional, mental and spiritual* - means that we provide a comprehensive and coordinated care approach, offering the following modalities:

Naturopathic Primary Care
Naturopathic Specialty Care
Nutritional Therapy
Injury Rehabilitation Massage
Myofascial Release
Acupuncture & East Asian Medicine
Functional Medicine
Classical Homeopathy
Occupational Therapy
Regenerative Injection Therapies

Many of these modalities are covered by insurance but some are not. Also some providers are in-network with certain insurance companies while others are not. **We will do our best to help you understand your benefits, but to prevent the stress of unexpected bills we urge you to find out which providers are in-network for your specific plan and what modalities your insurance does or does not cover.** Also please be aware that some services may go toward you deductible, in which case you are responsible for payment at the time of service. By beginning our relationship with a clear understanding of your insurance benefits, you are empowering yourself to receive the best possible care while minimizing any confusion or concerns down the road.

Please be aware that while your physician may order lab tests for you that they are only doing so on your behalf. What you might owe for lab tests and what is covered by insurance varies widely from network to network. **We will do our best to help you understand your benefits, but to prevent the stress of unexpected bills we urge you to contact your insurance company so you can have a good understanding of your lab benefits prior to completing any lab tests.** For your convenience, we have arranged for a lab company phlebotomist to be stationed in our building. However, we have no financial relationship with this or any other lab company. Your relationship with the lab companies is independent of your relationship with us.

In support of optimizing your health care experience, our in-house dispensary stocks hundreds of natural medicines, supplements and nutraceuticals. It is important to purchase or reorder these well before you run out. *Refill of prescriptions may take up to 48 hours - please plan accordingly.*

IMPORTANT: Appointments are often filled several weeks in advance. Cancellations made at least 24 hours in advance allow us to accommodate others and to provide the best care to the most people. **There is a $50 NO SHOW fee if a cancellation is not made at least 24 hours prior to your appointment.** We thank you in advance for your cooperation.

We need your help to protect our patients and staff/practitioners who are chemically sensitive to fragrances and other scented products (lotions, hair products, fabric softeners, etc.). **Thank you for not wearing any scented products on the day of your appointment**.

Warmly,

Your Heart of Wellness Care Team

Heart of Wellness PS

205 Clark Place SE, Tumwater, WA 98501 * PH: (360) 570-0401 * office@heartofwellness.org

DEMOGRAPHIC FORM

Patient Full Name: *(please include middle name)* _____

Nickname: *(what you would like us to call you)* _____

Date of Birth: _____ **Gender:** ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Domestic Partner

Employment Status: ☐ Employed ☐ Disabled ☐ Retired ☐ Not Employed

Employer: _____

Referral Source *(e.g. friend, google, facebook, etc.)***:** _____

Street Address: _____ **Home Phone:** _____

City, State, Zip: _____ **Work Phone:** _____

Email: _____ **Mobile Phone**: _____

Would you like to receive email reminders of appointments? ☐ yes ☐ no

Emergency Contact Name: _____ **Phone Number:** _____

Primary Physician: _____ **Referring Physician:** _____

Preferred Pharmacy Name: _____

Preferred Pharmacy Location: *(e.g. West Olympia, Martin Way, etc.)* _____

Payment Information:

Primary Insurance: _____ Secondary: _____ ☐ Self-pay

Relationship to Insured:

☐ Self ☐ Spouse ☐ Child ☐ Mother ☐ Father ☐ Other _____

If other than self please complete the following:

Insured's Name: _____

Insured's Date of Birth: _____

Heart of Wellness PS

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HEALTH HISTORY QUESTIONAIRE

Name: _____

Reason for Visit (list your main health concerns or reason for scheduling an appointment):

Primary Concern: _____

Is the concern related to: Work? ☐ Yes ☐ No Auto Accident? ☐ Yes ☐ No

What treatments have you tried? _____

_____

To what extent does it interfere with daily activities? (work, sleep, eating, etc...)_____

_____

Other Health Goals: _____

_____

Current Care (list ongoing care by providers outside heart of wellness, and conditions monitored)

Provider Name	Provider Type	Condition(s) Monitored

Surgeries/Hospitalizations: _____

_____

Health History (conditions and symptoms experienced recently)

DIGESTIVE
- ☐ Hemorrhoids
- ☐ IBS, Crohn's, or Ulcerative Colitis
- ☐ Gastritis or Peptic Ulcer
- ☐ Gallstones or Gallbladder Disease
- ☐ Liver Disease or Hepatitis
- ☐ Poor Appetite
- ☐ Excessive Appetite
- ☐ Cravings, What:_____
- ☐ Belching
- ☐ Heartburn or Acid Reflux
- ☐ Gas or Bloating
- ☐ Constipation or Chronic Laxative Use
- ☐ Blood in Stools/Black Stools
- ☐ Abdominal Pain/Cramps
- ☐ Rectal Pain
- ☐ Other

SKIN
- ☐ Eczema or Psoriasis
- ☐ Acne
- ☐ Fungal Infection/Athletes Foot
- ☐ Other_____

METABOLIC/ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Fatigue/Tiredness
- ☐ Loss of Sleep/Poor Sleep
- ☐ Night Sweats or Hot Flashes
- ☐ Weight Gain or Weight Loss
- ☐ Eating Disorder
- ☐ Other _____

GENITAL AND URINARY
- ☐ Kidney Stones
- ☐ Pain with Urination
- ☐ Urgency to Urinate
- ☐ Dribbling
- ☐ Incontinence
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Waking to Urinate
- ☐ Frequent Urinary Tract Infections
- ☐ Change in Libido
- ☐ Erectile Difficulties
- ☐ Other _____

CARDIOVASCULAR
- ☐ Heart Attack
- ☐ Stroke
- ☐ Elevated Lipids
- ☐ Vericose Veins, Phlebitis
- ☐ High or Low Blood Pressure
- ☐ Edema, Swelling of Hands or Feet
- ☐ Bleed or Bruise Easily
- ☐ Chest Discomfort or Pain
- ☐ Rapid or Irregular Heartbeat
- ☐ Heart Palpitations
- ☐ Fainting
- ☐ Cold Hands or Feet
- ☐ Other_____

INFLAMMATORY/IMMUNE
- ☐ Chronic Fatigue Syndrome
- ☐ Autoimmune Disease (e.g. RA, Lupus)
- ☐ Herpes (Oral or Genital)
- ☐ HIV Positive
- ☐ Cancer, type:_____
- ☐ Other _____

Heart of Wellness PS
HEALTH HISTORY QUESTIONAIRE

Health History (Continued)

VISION AND HEARING
- ☐ Dizziness or Vertigo
- ☐ Blurry Vision
- ☐ Floaters
- ☐ Eye Strain or Pain
- ☐ Eye Dryness
- ☐ Excessive Tearing
- ☐ Ringing in Ears
- ☐ Other _____

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sleep Apnea
- ☐ Chills (recent or persistent)
- ☐ Fever (recent or persistent)
- ☐ Sweat Easily
- ☐ Earaches
- ☐ Nose Bleeds

RESPIRATORY (Continued)
- ☐ Sores on Lips/Tongue/Mouth
- ☐ Recurrent Sore Throats
- ☐ Frequent Colds
- ☐ Swollen Glands
- ☐ Nasal Drainage
- ☐ Sinus Congestion
- ☐ Cough
- ☐ Phlegm
  Describe _____
- ☐ Difficulty breathing
  Describe _____
- ☐ Other _____

MOOD
- ☐ Nervousness/Irritability
- ☐ Easily Startled
- ☐ Excessive Worry
- ☐ Excessive Anger
- ☐ Excessive Fear
- ☐ Other _____

PSYCHOLOGICAL
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ ADD/ADHD
- ☐ Autism
- ☐ Other _____

NEUROLOGIC
- ☐ Cognitive Impairment
- ☐ Memory Problems
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Concussion
- ☐ Migraines
- ☐ Headaches
  When _____
  Where _____
- ☐ Slurred speech
- ☐ Tremors
- ☐ Other _____

Women's Health History

Are you pregnant? ☐ Yes ☐ No

Age at First Period _____
Last Menstrual Period _____
Average length of full cycle _____
Average Duration of Flow _____
- ☐ Irregular Cycle
- ☐ Skipped Cycles
- ☐ Hormonal Contraception Use
- ☐ Heavy Flow
- ☐ Clots
- ☐ Pain or Cramps
  When _____
- ☐ PMS Symptoms
  Describe _____
- ☐ Perimenopausal
- ☐ Menopause
- ☐ Infertility
- ☐ Fibrocystic Breasts
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Frequent Yeast Infections

____ Number of Pregnancies
____ Number of Births
____ Caesarean Births
Other _____

Family History

Check if Applicable	Mother	Father	Brothers	Sisters	Maternal GM	Maternal GF	Paternal GM	Paternal GF
Cancer								
Diabetes								
Heart Disease								
High Blood Pressure								
Stroke								
Mental Illness								
Allergies/Asthma/Hives								
Other								

Known Allergies or Hypersensitivities

Drugs: _____

Foods: _____

Environmental Allergens (e.g., lotions, oils, fragrances): _____

Heart of Wellness PS
HEALTH HISTORY QUESTIONAIRE

Nutrition History

Height (feet/inches) _____ Usual Weight Range +/- 5 lbs _____ Highest adult weight _____

Current Weight _____ Desired Weight Range +/- 5 lbs _____ Lowest adult weight _____

Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No

If yes, describe: _____

How often are your bowel movements? _____ Are they: ☐ formed ☐ Loose/Soft ☐ Hard

Caffeine, Alcohol, and Tobacco

Drinks per day of coffee, tea, or soda: _____ Drinks a week containing alcohol: _____

Currently Smoking: ☐ Yes ☐ No How many years: _____ Packs per day:____ Attempts to quit: ____

Previous Smoking: ☐ Yes ☐ No How many years: _____ Packs per day:____

Exercise

Current Exercise Program: (activity, sessions/week, and duration)_____

_____

List any problems that limit activity:_____

Sleep

Average number of hours you sleep per night: < 6 6-8 8-10 >10

Do you have trouble falling or staying asleep: ☐ Yes ☐ No Do you use sleeping aids: ☐ Yes ☐ No

Stress and Coping

Do you feel you have excessive stress in your life: ☐ Yes ☐ No

Do you feel you easily handle the stress in your life: ☐ Yes ☐ No

Have you experienced a recent major loss : ☐ Yes ☐ No

Are currently in counseling or therapy: ☐ Yes ☐ No

Stressors (Rate 1-10): Work___ Family___ Social___ Finances___ Health___ Other_____

Do you practice meditation or relaxation techniques: ☐ Yes ☐ No How often:_____

MEDICATIONS (Please ask reception for an additional sheet if you need more space)

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

Have medications or supplements ever caused you unusual side effects or problems ☐ Yes ☐ No

Describe: _____

Heart of Wellness PS
HEALTH HISTORY QUESTIONAIRE

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

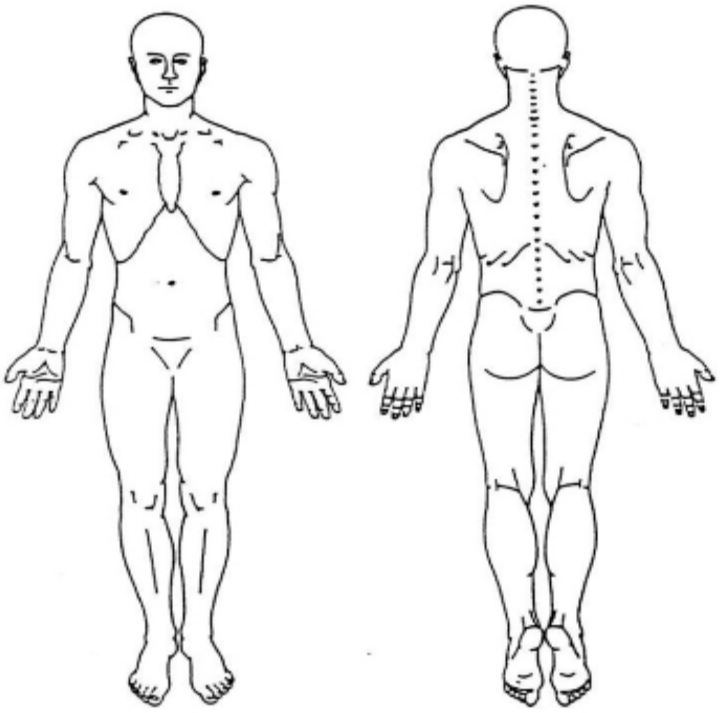
Supplement	Dose	Frequency	Start Date (month/year)	Reason For Use

Physical History (indicate if you experience any of the following)

☐ Muscle Cramps or Spasms
☐ Easily Bleed or Bruise
☐ Swelling
☐ Hand, Wrist, or Elbow Pain
☐ Numbness in Hands or Feet
☐ Carpal Tunnel Syndrome
☐ Neck Pain or Whiplash
☐ Thoracic Outlet Syndrome
☐ Upper or Mid Back Pain
☐ Low Back Pain
☐ Herniated or Bulging Disk(s)
☐ Sciatic Pain
☐ Arthritis
☐ Fibromyalgia or Chronic Pain
☐ Other_____

Use the following diagram to indicate painful or distressed areas:

✕ pain → radiating/electrical pain numbness



Additional Details:

How severe the pain now (0-10)? _____ The most severe in the last week (0-10)? _____
Frequency of pain: ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent
Since onset, pain is: ☐ Better ☐ Same ☐ Worse
Symptoms are most present: ☐ Waking ☐ Morning ☐ Mid-day ☐Evenings ☐ Night
Do you sit for long hours at a computer workstation or driving? ☐ Yes ☐ No

χPlease email me my transaction receipt to: **Heart of Wellness**

MEDICAL RECORDS RELEASE FORM

For new patients wanting to receive optimum care, please drop off at your previous doctors' office 2-4 weeks prior to your first appointment so that we can have your old records on file when you come in.

I,_____ (Patient Name) born on _____/_____/_____(Date of Birth) authorize the release of my information to Heart of Wellness. Previous provider(s) are authorized to make the disclosure. Please release the following information:

- Problem list
- Medication list
- List of allergies
- Immunization record
- Most recent history and physical
- Progress notes **from the last 3 appointments**
- Most recent discharge summary
- Laboratory results **from the last 12 months**
- X-ray & imaging reports **- last 12 months**
- Consultation reports **from the last 6 months**

I hereby authorize all providers receiving this form to release all or whatever part of the aforementioned information they may have in their records. I also specifically request that Heart of Wellness contact the following providers in order to receive information pursuant to this release form.

Provider: _____ Provider: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed to and used by:
Heart of Wellness, 205 Clark Place SE, Tumwater, WA 98501
Phone: 360-570-0401 Fax: 360-570-2060 Email: info@heartofwellness.org

For the purpose of: Transfer of Primary Medical Care or Consultation

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at the end of the pending of any claim or lawsuit.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact: U.S. Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue SW, Washington DC, 20201 Phone: (866) 627-7748 Web: www.hhs.gov

_____ _____

Patient's Signature (Parent/Guardian) **Date**

Heart of Wellness PS
BENEFITS VERIFICATION FORM*

Please use this form when calling your insurance company to verify benefits.

Date:

Name: DOB:

Insurance ID# HOW Clinician(s):

Contact member services at the phone number listed on the back of your insurance card. Please ask the following questions to verify your insurance benefits for alternative care. Completing this form with as much detail as possible will assist Heart of Wellness and you to achieve your maximum insurance benefits. It is vital that you record the name of the person you spoke with and any reference number they can give you. This will also assist us should your claims be denied by your insurance.

Questions	Naturopathic Primary Care	Acupuncture	Massage Therapy	Occupational Therapy
Do I have benefits for				
How many visits am I allotted per year?				
How many units am I allotted per visit? (1 unit = 15 minutes)	N/A			
Do I need a referral or prescription?				
Do I need an authorization?				
My co-pay per visit is				
My co-insurance per visit is				
Does my deductible apply to these services?				

DEDUCTIBLE: My individual deductible is $_____. My family deductible is $_____.

I have met $_____ of my individual deductible and $_____ of my family deductible.

Have I met my yearly out-of-pocket maximum?

LAB TESTS: Do I have laboratory benefits? _____ If yes, what is my responsibility?

Do I have a deductible for laboratory tests?

Insurance Representative:

Reference #

***As insurance benefits can change annually, this form must be completed yearly or when new coverage begins.**

Heart of Wellness PS

205 Clark Place SE, Tumwater, WA 98501 * PH: (360) 570-0401 * info@heartofwellness.org

FINANCIAL POLICY

Effective Date: 09/01/13 Revised on: 01/02/17

Welcome to Heart of Wellness ~ We recognize that the financial aspects of healthcare can be confusing, and will do our best to help make the process as easy as possible.

Financial Responsibility ~ Our physicians and other practitioners are preferred providers for numerous insurance companies. As long as we have accurate and current insurance information, we will courtesy bill your insurance company for you. However, it is important for you to understand that you, the patient, are ultimately responsible for the payment of medical services you have received. Cash, personal check, Visa, MasterCard and Discover are accepted methods of payment.

Insurance ~ We require a copy of your driver's license/identification card and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information at each visit, you may be held responsible for the balance of the claim. Insurance is a contract between you and your insurance company; we are NOT a party to this contract. We will prepare and send a claim as a courtesy for you. If your insurance company delays payment or refuses to pay, you are responsible for the full amount due.

WE ARE CURRENTLY CONTRACTED WITH THE FOLLOWING INSURANCE NETWORKS / PAYERS
(not all clinicians are contracted with every network – please check with your insurance company)

- Regence Blue Shield
- Uniform Medical
- BridgeSpan
- First Choice
- Aetna
- Premera Blue Cross
- Lifewise
- Optum / United Health
- Group Health PPO (Options)
- Cigna
- Workers Compensation
- Motor Vehicle (MVAs)
- Some Medicaid Plans
- Medicare Coming Soon
- Ask about others

Copays and Coinsurance ~ Co-payments required by your insurance company must be paid at the time of service. Collection of copays and coinsurance amounts are an insurance requirement, and failure on our part to collect can be considered fraud.

Non-covered Services ~ Please be aware that some, and perhaps all, of the services you receive may be non-covered by your insurance plan. While our office may be aware of the restrictions of our contracted plans, our patients represent many insurance companies and many different plans. Unfortunately, we will not be able to know for certain if your insurer will "cover" your services. However, if in our opinion, the service you are receiving may not be covered, you will be asked to pay at the time of service.

Statements & Past Due Balances ~ Whatever balance your insurance does not pay, you are responsible for paying. Unpaid balances are due upon receipt of an invoice or statement. Any outstanding unpaid balances will be charged to your credit card on file. Partial payments or payment plans may be accepted if negotiated with Heart of Wellness. If a balance remains unpaid, we may refer your account to a collections agency, and you and your immediate family members may be discharged from this practice.

Billing & Credit Card Authorization ~ Completion of the Billing & Credit Card Authorization form is mandatory for all patients. In the absence of a credit card authorization, or in the event that an authorized charge is declined, a billing fee of $20 will be added to your account for any balances that remain due after 28 days from the receipt of a statement. Furthermore, an outstanding balance charge of 1.5 percent of the total bill will be charged for each month that the bill remains unpaid.

Payment at Time of Service ~ *No Insurance? No Problem.* At Heart of Wellness we think high-quality integrative medical care should be accessible to everyone, including patients without health insurance. Hence we offer a ~35% discount when you pay at the time of service. The amount of the discount represents the savings in not having to bill you or an insurance company. If you want to pay at the time of service please let us know at the time you schedule your appointments.

Cancellations ~ In consideration of our goal of making high-quality integrative healthcare available to as many people as possible, we ask that you give us notice by 2:00 pm the day before the appointment for any cancelations. For Monday appointments we ask that you provide notice by 2:00 pm the Friday before. There is a $50 charge for all missed appointments or for cancellations initiated with less than 24 hours notice prior to the appointment. This fee is not billable to insurance and will be charged to your credit card on file. At our discretion, unavoidable emergencies may be considered reasonable exceptions. If you miss three appointments or have three late cancellations you and your immediate family members may be discharged from this practice.

Special Fees ~ We reserve the right to charge for the following services:

Late Cancellation Fee	$50.00	Disability, FMLA & Miscellaneous Forms	$30.00
MVA & Other reports	$30.00	Returned Checks	$30.00
Copying Medical Records	$20.00	Emergency Phone Calls	$50.00

*Note ~ These fees are not generally billable to insurance. When not billed to insurance they are due and payable immediately and will be charged to your credit card on file unless you provide payment at the time of service.

NOTICE OF ACKNOWLEDGEMENT: I acknowledge that I have read and agree to Heart of Wellness's Financial Policy.

Patient Name: _____

Signature: _____ **Date:** _____

Heart of Wellness PS

205 Clark Place SE, Tumwater, WA 98501 * PH: (360) 570-0401 * info@heartofwellness.org

BILLING & CREDIT CARD AUTHORIZATION

Patient Name: ______________________________ **DOB:** ______________

Payment Option #1: Credit Card On File

I, ________________________________, authorize and request Heart of Wellness to charge the credit/debit card account named below as outlined in the Heart of Wellness Financial Policy. I understand that co-pays, cash-pay services, non-covered service charges and service charges going toward deductibles will be charged at the time of service. After Heart of Wellness has submitted or resubmitted charges to my insurance carrier and after my insurance carrier processes my claim, then any amounts remaining due will then charged to my card within 3 business days of the 20th of the month, with a receipt to be sent to me via email. This authorization is good until I revoke it in writing with a 30 day notification period and choose another payment option to commence at the end of that period.

Discover VISA Mastercard

Name as it appears on card: ____

Card # __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __ Expiration Date: _____ / ______

Billing Address: ______________________________ 3 Digit Security Code: ___________

____

____

Patient / Guarantor Signature: ______________________________ Date: ____________________

_ _

Payment Option #2: Patient Billing

I, ________________________________, agree to pay all charges according to the Heart of Wellness Financial Policy. I agree to pay at the time of service all applicable co-pays, cash-pay services, non-covered service charges, service charges going toward deductibles, or other charges as outlined in the Heart of Wellness Financial Policy. In the event that a balance remains due after Heart of Wellness has submitted or resubmitted charges to my insurance carrier and after my insurance carrier processes my claim then please send me a statement. I agree to remit payment immediately upon receipt of this statement.

Furthermore, I agree that if I do not pay any outstanding balance within 28 days of receipt of this bill the following additional charges will apply:

- $20.00 one-time per incident administrative fee
- 1.5% outstanding balance charge per month until all balances are paid in full

Patient / Guarantor Signature: ______________________________ Date: ____________________

Heart of Wellness PS

INFORMED CONSENT AGREEMENT

This Document Constitutes an Agreement: We have written this document to inform you about our practice, to ensure that you understand our professional relationship, and to obtain your informed consent in this relationship. Your informed consent is important not only because it protects both parties in this agreement, but also because it helps you to feel empowered in your own healing process, which in turn encourages healing at all levels of your being. When you sign this document, it will authorize us to initiate care and commence treatment in accordance with this document. Please read this document carefully and bring any questions you might have to your first meeting with a Heart of Wellness practitioner. Please also be responsible for maintaining clarity and communication regarding your ongoing informed consent. If at any time you are uncomfortable or dissatisfied with your care or treatment, for any reason, please let us know immediately.

Purpose of Treatment & Therapeutic Orientation: Heart of Wellness is an integrative and collaborative medical group practice dedicated to helping you achieve and maintain optimum health at all levels of your being. We will help you as best we can to resolve your complaints and to achieve your health goals. In addition, we will also seek to remind you of the opportunities for the realization of optimum health and wellbeing that are available in the midst of any illness or difficulty. We understand healing as a natural process, and our fundamental goal in relation to this natural process is to support, facilitate and empower you in your own healing journey. We invite you to take full responsibility for your own healing journey.

Naturopathic Medicine Practice & Limitations: Naturopathic Physicians currently practicing at Heart of Wellness include Dr. Laura Jimenez-Robertson ND (NT60285540), Dr. Tim Shannon ND (NT60332027), Dr. Michele Deisering ND (NT60332030), Dr. Diana Duncan ND (NT60464581), Dr. Katie Shaff ND (NT00001331), and Dr. Gregory Robertson ND (NT60257265). In the State of Washington, naturopathic medical practice includes the prescription, administration, dispensing, and use of: nutrition and food science, homeopathy, hygiene, immunizations & vaccinations, contraceptive devices; non-legend medicines including vitamins, minerals, botanical medicines, homeopathic medicines, and hormones; and legend drugs with the exception of Botox and certain controlled substances. The practice of naturopathic medicine also includes manual manipulation, physical modalities, minor office procedures, common diagnostic procedures, and suggestion. Naturopathic physicians may not treat malignancies except in collaboration with a Medical Doctor (MD) or Osteopathic Physician (DO). Therefore, if you have cancer, or suspect you have cancer, we require you to be under the ongoing care of a board-certified oncologist or other MD or DO with experience working with malignant conditions. If you have cancer or suspect you have cancer, by signing this document you hereby agree to remain under the continuing care of a qualified MD or DO and you agree that your relationship with this MD or DO shall be the primary therapeutic relationship and the care you receive at Heart of Wellness shall be secondary and supportive.

East Asian Medicine Practice & Limitations: Acupuncture & East Asian Medicine Practitioners currently practicing at Heart of Wellness include David Lerner MTCM, EAMP (AC217 – licensed in WA since 1994), Morgan Tougas MAOM, EAMP (AC2943 – licensed in WA since 2006), and Fred Klemmer MTCM, EAMP (AC2147 – licensed in WA since 2003). East Asian Medicine includes the following diagnostic tools and treatment methods used to promote health and treat organic or functional disorders: acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians; use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians; moxibustion; acupressure; cupping; dermal friction technique; infrared; sonopuncture; laserpuncture; point injection therapy (aquapuncture); dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements; breathing, relaxation, and East Asian exercise techniques; Qi Gong; East Asian massage; Tui Na; and superficial heat and cold therapies. Potential side effects of these therapies may include, but are not limited to, the following: discomfort during treatment, pain following treatment; minor bruising or swelling; infection; minor burns, “needle sickness” (including dizziness or fainting); and broken needle. In addition, it is important that you understand that under Washington State law the techniques of East Asian Medicine are not considered capable of resolving certain potentially serious health disorders, including but not limited to uncontrolled high blood pressure, other serious cardiac conditions, acute abdominal symptoms, acute neurological changes, unexplained weight loss or gain, fracture or dislocation, systemic infection, any serious bleeding disorder, or acute respiratory distress. If you

have or suspect you may have any of these disorders, or any equally serious condition, or if you have a pacemaker installed, or if you are pregnant, by signing this agreement you hereby agree (1) to inform your EAMP practitioner of this condition, (2) to remain under the continuing care of a qualified physician (MD or DO or ND), and (3) to provide us with continuing authorization to consult with this physician. By signing this agreement you further agree that your relationship with this physician shall be the primary therapeutic relationship and that the East Asian Medicine care you receive shall be secondary and supportive in nature.

Occupational Therapy Practice & Limitations: Licensed Occupational Therapists currently practicing at Heart of Wellness include Amy Howell (OT00002292). Occupational therapy is the scientifically based use of purposeful activity with individuals who are limited by physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, or the aging process in order to maximize independence, prevent disability, and maintain health. The practice encompasses evaluation, treatment, and consultation. Specific occupational therapy services include but are not limited to: Using specifically designed activities and exercises to enhance neurodevelopmental, cognitive, perceptual motor, sensory integrative, and psychomotor functioning; administering and interpreting tests such as manual muscle and sensory integration; teaching daily living skills; developing prevocational skills and play and avocational capabilities; designing, fabricating, or applying selected orthotic and prosthetic devices or selected adaptive equipment; wound care management as provided in RCW 18.59.170; and adapting environments for persons with disabilities. These services are provided individually, in groups, or through social systems.

Massage Practice & Limitations: Licensed Massage Practitioners currently practicing at Heart of Wellness include Manuela Egolf (MA60311090) and Gary Black (MA60326924). Massage involves the external manipulation or pressure of soft tissue for therapeutic purposes, including techniques such as tapping, compressions, friction, reflexology, gymnastics or movements, gliding, kneading, shaking, and fascial or connective tissue stretching, with or without the aids of superficial heat, cold, water, lubricants, or salts. Massage does not include diagnosis or attempts to adjust or manipulate any articulations of the body or spine or mobilization of these articulations by the use of a thrusting force, nor does it include genital manipulation. By signing this agreement you assert your understanding of the scope of massage and acknowledge that massage is not a substitute for medical examination or diagnosis.

Having read and understood the foregoing: By signing below you are asserting your understanding of and agreement with the entirety of this agreement and voluntarily consenting to treatment as outlined here, while also acknowledging that you are free to withdraw consent and to discontinue treatment at any time. By signing below you are authorizing physicians and other practitioners at Heart of Wellness to provide all examinations, treatments and/or diagnostic procedures which now or during the course of your care they deem advisable. By signing below you are acknowledging that while the course of treatment is designed to be helpful, it may at times be difficult and uncomfortable, and that there is no guarantee that there will be any benefit from treatment. By signing below you are agreeing that you and no one else is responsible for your own healing and that maximum benefit will occur with consistent treatment and compliance and when you take full responsibility for your own healing journey. By signing below you acknowledge that Heart of Wellness is responsible only for the failure to perform your treatment with appropriate care. By signing below you are certifying that you have read and understood all preceding information and you are committing to immediately notifying your Heart of Wellness practitioner or other Heart of Wellness staff if you have any questions or should concerns arise at any time during the course of your treatment.

Mailing List: By signing below I further consent to be added to the Heart of Wellness mailing list, from which I can unsubscribe at any time.

Confirmation of Review of Notice of Privacy Practices: By signing below I further confirm that I have reviewed the Heart of Wellness **Notice of Privacy Practices** and have been offered a copy of the notice for my records.

Patient's Name (Please print): _____

Patient's Signature: _____ **Date Signed:** _____