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
Acupuncture & East Asian Medicine
Functional Medicine
Myofascial Release Therapy

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

Revised 1/1/18

Heart of Wellness

205 Clark Place SE Tumwater, WA 98501 Ph 360-570-0401 info@heartofwellness.org

Patient Demographics

Date Completed: _____ How did you hear about us? _____

Full Legal Name: _____

How would you like to be addressed? _____

Name of Parent(s) if patient is a child: _____

Date of Birth: _____/_____/_____ Legal Gender: M F

Gender Identity? (optional) _____

Marital Status: Single Married Widowed
Divorced/Separated Other:_____

Physical Address: _____
_____
_____
_____

Mailing Address: _____
_____
_____
_____

Home Ph: (_____) _____-_____
Work Ph: (_____) _____-_____

Mobile Ph: (_____) _____-_____
Other Ph : (_____) _____-_____

Email Address: _____
Would you like email reminders of appointments: YES NO

Employment Status: Full-Time Part-Time Retired Self Disabled Unemployed

Employer's Name: _____

Employer's Address: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Emergency Contact Relationship: _____

Do you have a primary physician (other than Heart of Wellness): YES NO

Name: _____

Preferred Pharmacy: _____

Location: _____

Heart of Wellness

205 Clark Place SE Tumwater, WA 98501 Ph 360-570-0401 info@heartofwellness.org

Financial Information*

***Please see our financial policy for full details of financial agreement**

If the patient is a minor or an incapacitated adult, who is the Guarantor? _____

Primary Insurance Company Name: _____

Prefix:_____ ID #: _____ Group #: _____

Policy Subscriber: _____ DOB: _____

Relationship to Patient: _____ Is this an employer sponsored plan? Y N

Secondary Insurance Company Name: _____

Prefix:_____ ID #: _____ Group #: _____

Policy Subscriber: _____ DOB: _____

Relationship to Patient: _____ Is this an employer sponsored plan? Y N

Please provide a copy of the front and back of your insurance card(s) for billing. We cannot bill your insurance without copies on file

Cost Sharing Program: _____

Who will submit claims for payment? Self HoW

Self Pay Options:

❑ Pay At Time of Service ❑ Membership

Bronze Silver Gold Platinum

Signature: _____ Date: _____

Revised: 12/29/2017

Heart of Wellness PS

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

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)

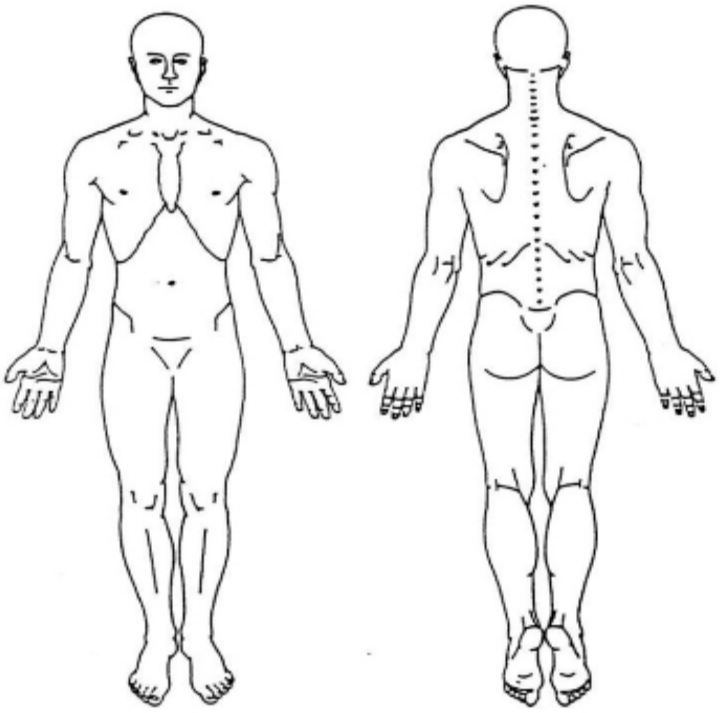
Supplement	Dose	Frequency	Start Date (month/year)	Reason For Use

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

Heart of Wellness PS

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

FINANCIAL POLICY

Effective Date: 01/01/2018 Revised: 12/26/17

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 payment for all services you receive. Cash, personal check, Visa, MasterCard and Discover are accepted methods of payment. We also have our Optimal Health Membership Program.

Insurance ~ We require a copy of your driver's license/identification card and current valid insurance card to provide proof of insurance at the time of your appointment. If you fail to provide us with the correct insurance information at each visit, you may be held responsible for the full amount due for services you receive. Insurance is a contract between you and your insurance company; we are NOT a party to this contract. All copays must be paid at the time of service.

WE CURRENTLY HAVE CLINICIANS WHO ARE IN-NETWORK WITH THE FOLLOWING THIRD-PARTY PAYERS
(not all clinicians are available with every network – please check with your insurance company and then with us)

- Regence Blue Shield
- Uniform Medical
- BridgeSpan
- First Choice Network Plans
- Aetna/Sound Health
- Premera Blue Cross
- Lifewise
- Optum/United Health PPO
- Kaiser Permanente PPO
- CIGNA
- Workers Compensation
- Motor Vehicle (MVAs)
- Some Apple Health Plans
- Liberty HealthShare
- Ask about others

Non-covered Services ~ Please be aware that some of the services you receive may be not be covered by your insurance plan. We may not be able to know for certain if your insurer will cover the services you receive. If we believe that the service you are receiving will not be covered, you may 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 will not be accepted unless otherwise 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. We offer a 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 when you schedule your appointment.

Optimal Health Membership Program ~ Our membership program offers an affordable alternative to payment at the time of service for a comprehensive range of our services including physician services, nutritional support, acupuncture and massage. This program can be especially helpful for patients with high-deductible insurance plans.

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: These fees are not generally billable to insurance.

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

Supplement Sales ~ With some limited exceptions, all supplement purchases are final.

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

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. Courtney Addabbo ND (NT60740400). 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 that the care you receive at Heart of Wellness shall be secondary and supportive of your general health and shall not be understood as treatment of a malignancy.

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 Therapy Practice & Limitations: Licensed Massage Therapists currently practicing at Heart of Wellness include Gary Black (MA60326924). Massage therapy 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 therapy and acknowledge that massage therapy 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 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 confirm that I have reviewed and understand the Heart of Wellness **Notice of Privacy Practices**, that I understand that I am entitled to keep a copy of the notice for my records, and that further copies are available at the Heart of Wellness offices or for download on the Heart of Wellness website.

Patient's Name (Please print): _____

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

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
2018 BENEFITS VERIFICATION FORM*

This form is designed to help you in verifying your benefits with your insurance company.

This form is optional however we strongly suggest completing it to gain important information regarding insurance coverage.

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 Medicine	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)				
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 should be completed yearly or when new coverage begins.**

DID YOU KNOW THAT MEDICARE and TRICARE DO NOT RECOGNIZE HEART OF WELLNESS CLINICIANS?

What does that mean for you?

- Heart of Wellness cannot bill Medicare or Tricare for our services.
- Medicare and Tricare will not pay for any services we recommend, including labs.
- Heart of Wellness has made arrangements with a cash-only lab that offers significantly reduced cash rates in lieu of billing Medicare or Tricare.
- Your supplement plan may not pay for anything we prescribe.

If you are a subscriber of Medicare and/or Tricare it is important that you we know!

We require all patients to complete either OPTION 1 or OPTION 2 below:

OPTION 1: NO, I AM NOT A MEDICARE OR TRICARE SUBSCRIBER

I, _____ am not a subscriber to Tricare or any part of Medicare.

_____ _____

Signature of Patient or Parent or Guardian if applicable Date

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OPTION 2: YES, I AM A MEDICARE OR TRICARE SUBSCRIBER

I, _____ am a subscriber of the following plans (check all that apply):

- ☐ Medicare Part A – Hospital, SNF and Hospice Coverage
- ☐ Medicare Part B – Physician, Lab and Diagnostic Coverage
- ☐ Medicare Part C – Combination of A and B via a 3rd Party (aka Medicare Advantage)
- ☐ Medicare Part D – Prescription Drug Coverage
- ☐ TriCare or other military insurance administered by the federal government

_____ _____

Signature of Patient or Parent or Guardian if applicable Date

Informed Consent for Therapeutic Massage

Licensed Massage Therapists currently practicing at Heart of Wellness include Gary Black (MA60326924). Massage therapy 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 therapy and acknowledge that massage therapy is not a substitute for medical examination or diagnosis.

Massage Therapy as practiced at Heart of Wellness does not include breast massage but can include chest massage, which includes manipulation of the muscle, fascia and connective tissue of the upper torso and traction engaging the sternum and rib cage. Massage Therapy does not include genital manipulation but can include manipulation of the gluteal muscles and manipulation of muscle attachments located on the pubic and pelvic bones.

Draping is provided so that the genitals and tailbone are always covered. For women the breasts are also always covered, while for men the entire chest may at times remain uncovered unless you tell your massage therapist that you would like your breasts to be covered.

You always have the right to discontinue the entire massage therapy session, or any part of the session, at any time and for any reason. You have the right to request, at any time and for any reason, that the massage be given through a drape rather than directly on your body. You also have the right to provide a witness who will be in the room with you while you receive massage therapy. Please let your massage therapist know immediately if you change your mind or if any part of the treatment process feels uncomfortable in any way.

By signing this form you are providing your informed consent to treatment as outlined here, should you decide to receive massage therapy services at Heart of Wellness.

_____

Patient Name

_____

Guardian Name (if applicable)

_____ _____

Patient / Guardian Signature Date