Patient Information Form

BASTYR University CLINIC

Last Name: ____________ First Name: ____________ Middle Name: ____________

Preferred Name: ____________ SS#: ______ - ______ - ______

Date of Birth (*required*): ______ / ______ / ______ Gender: ____________

Address: ____________ Unit #: ______ City: ____________

State: ______ ZIP: ______ Email: ____________

Other name(s) that records may be kept under: ____________

Phone

Appointment reminders will be send to 1st preference

1. ☐ Home ☐ Work ☐ Cell (______) ____________ 2. ☐ Home ☐ Work ☐ Cell (______) ____________

***Confidential voicemails OK?** ☐ Yes ☐ No ***Confidential voicemails OK?** ☐ Yes ☐ No

Emergency Contact

Name: ____________ Phone: ____________ Relationship: ____________

Are you currently employed? ☐ No ☐ Yes Employee/Address: ____________

Are you a Bastyr employee or student, or significant other of one? ☐ No ☐ Yes Please specify: ____________

Insurance Information

Primary Insurance: ____________ Policy #: ____________ Group #: ____________

Subscriber ____________ Date of Birth (*required*): ______ / ______ / ______

Secondary Insurance: ____________ Policy #: ____________ Group #: ____________

Subscriber ____________ Date of Birth (*required*): ______ / ______ / ______

Please check below if applicable

☐ Auto Accident ☐ Workers Compensation Date of accident or injury: ____________ Claim #: ____________

Parent/Guardian/Information

To be filled out if patient is a minor, or if someone other than the patient is medically and financially responsible for the patient.

Mother's Name (*minors only*): ____________

Legal Guardian? ☐ Yes ☐ No Date of Birth (*required*): ______ / ______ / ______

Father's Name (*minors only*): ____________

Legal Guardian? ☐ Yes ☐ No Date of Birth (*required*): ______ / ______ / ______

Other Legal Guardian Name: ____________

Relationship to Patient: ____________ Date of Birth (*required*): ______ / ______ / ______

I hereby acknowledge that I am the guarantor and financially responsible for payment of all services rendered, and that I am subject to all terms on the financial consent form.

Patient Signature (*18 and older*): ____________ Date ______ / ______ / ______

Parent/Guardian Signature : ____________ Date ______ / ______ / ______

Last Revised June 2016

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BASTYR University CLINIC

Demographic Data Collection

Bastyr is committed to providing quality care for all patients. We are asking you to provide your marital status; your racial and ethnic background; the language you prefer to use when speaking with your doctor; and whether you are or were military. Your answers are both voluntary and private. Thank you for your cooperation.

What is your marital status?

☐ Single ☐ Married ☐ Significant other ☐ Widowed

Do you consider yourself Hispanic or Latino? Please check one:

☐ I AM Hispanic or Latino ☐ I don't know

☐ I am NOT Hispanic or Latino ☐ Decline to answer

Which category best describes your race? You may circle one or more:

☐ White or Caucasian ☐ American Indian ☐ Other race

☐ Black or African American ☐ Alaskan Native ☐ I don't know

☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Decline to answer

What is your preferred language when speaking with your doctor?

☐ English ☐ Other (please specify): ____________________

Do you need an interpreter? ☐ Yes ☐ No

Are you active military or veteran?

☐ Yes

☐ No

☐ Decline to answer

How did you hear about us?

☐ Friend/Patient ☐ External Referral ☐ Walk By

☐ Event/Health Fair ☐ Staff/Student ☐ Website

☐ Shuttle/Bus ☐ Current Patient ☐ Social Media

☐ Physician/Specialist ☐ Radio/TV ☐ Yelp

PSR initials: ____________

Patient Profile

Last Name: ______________________ First Name: ____________________________ Middle Initial: ___________

Nickname: ______________________ Date of Birth ______ / ______ / ______ Gender: ______

A note to our patients: Please complete this **3-page questionnaire** as thoroughly as possible in order to aid your clinician in their diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except if you have provided us with written authorization. Thank you for your help.

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

____

____

Who is your Primary Care Provider? ______________________________________ Phone: (____) ______________

Please list other providers/specialists involved in your care and their clinic phone number:

____

____

If you are seeking adjunctive Cancer support, who is your Oncologist?

Oncologist? ____ Phone: (____) ______________

When was your last physical? ____________________ When did you last have bloodwork? ____________________

Please indicate the type of care you are seeking

☐ Primary management of my health

☐ Adjunctive care for my health

☐ On-going management of my health

☐ One time advice for my health

☐ I don't know at this time

Have you ever consulted a Naturopathic Physician, Acupuncturist, Nutritionist or Counselor before? ☐ Yes ☐ No

If YES, please circle which type of practitioner you've previously consulted with.

In general would you say your health today is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Patient Profile

BASTYR University CLINIC

Last Name: ______________________ First Name: ________________________ Date of Birth _____ / _____ / _______

Do you have any **medication allergies or any allergic reactions** to anything else? ☐ Yes ☐ No

If **YES** please explain: ____

____

Please list all medications and supplements you are taking including prescriptions, over-the-counter medications, vitamins, minerals, herbs and homeopathic remedies. Attach another page if needed.

Name of medication *(such as Synthroid, Vitamin D, etc.)*	**Strength** *(88mcg, etc.)*	**Directions** *(such as 1 tablet twice a day, as needed, etc.)*
☐ Check if none		

Medical History

Please check box to indicate if you or a family member has ever had the following conditions. If condition does not apply leave blank. Please indicate which relative has the condition, if applicable such as mother (M), father (F), sibling (S) or maternal or paternal grandmother/grandfather (MGM, MGF, PGM, or PGF).

Condition	SELF	RELATIVE	Condition	SELF	RELATIVE
Allergies			HIV/AIDS		
Anemia			Hypertension		
Anxiety			Irritable Bowel Syndrome		
Arthritis			Kidney Disease		
Asthma			Meningitis		
Blood Transfusion			Nerve/Muscle Disease		
Cancer			Osteoporosis		
Cataracts			Parkinson's/Alzheimer's		
Congestive Heart Failure			Seizures		

Patient Profile

BASTYR University CLINIC

Medical History continued

Last Name:________________________ First Name:___________________________ Date of Birth _____ / _____ / _______

Condition	SELF	RELATIVE	Condition	SELF	RELATIVE
Clotting Disorder			Sickle Cell Anemia		
COPD			Stroke		
Depression			Substance Abuse		
Diabetes			Thyroid Disease		
Emphysema			Tuberculosis		
GERD			Ulcers		
Glaucoma			Other		
Heart Attack			Other		
Heart Murmur			Other		

Please list any surgeries or hospital stays you have had and their approximate date/year:

Type of surgery/reason for hospitalization: *Date:*

____ _______ / _______ / _________

____ _______ / _______ / _________

Social History

Do you use any of the following substances regularly?

☐ Coffee/Black Tea/Cola ☐ Alcohol ☐ Recreational Drugs ☐ Tobacco- Current/Past/Never

If Current or Past Tobacco Use: Packs Per Day: _______ How Long: _______ Quit:__________________

Please mark those that apply: ☐ Single ☐ Married ☐ Significant Other ☐ Divorced Other: ____________________

Do you have children? ☐ Yes ☐ No If YES, what are their ages: ____

Do you follow any particular diet restrictions? ☐Yes ☐No If Yes, please describe: ___________________________

____

Do you exercise regularly? ☐Yes ☐No If YES, please describe type of exercise and how often. ____________________

____

____ ________________________________

Patient/Guardian (Print Name): **Date**

____ ________________________________

Patient/Guardian Signature: **Date of birth**

Reviewed by Provider and ready to be scanned to EPIC (Initals): _________________ **Date:** ______ / ______ / ________

Financial Agreement

BASTYR University CLINIC

Thank you choosing Bastyr University Clinic to seek your health care.

What you should know:

Health insurance is a contract between you and your insurance company. It's best if you know which services your insurance will cover before you receive care. That way, there are no surprises for either of us. If you are not sure about your coverage, please ask your insurance company. Refer to the back of your insurance card. If you don't have insurance, we have many discounted contracts you may qualify for; please ask us.

Insurance billing

- Contract coverage: Bastyr contracts with many insurance plans. If we are in your health plan's network, you are expected to pay any cost shares at the time of service
- Non-contracted: If your insurance plan is not contracted with Bastyr we will bill your insurance as a courtesy to you. You are responsible for the full cost of care. If your insurance does not pay within 45 days, the balance will be billed to you.

Care or services not covered by your insurance plan

Bastyr has many services that are non-covered by insurance plans. Some services might be considered experimental for research purposes only by your insurance company. If that is the case, you will be responsible for the full cost. We expect payment at the time of the service.

Nonpayment

If you have not pay your bills within 30 days after receiving your final notice you will be turned over to the collection agency Professional Credit Services. You will be responsible for any collection agency fees that apply. If you have large unpaid balances and make no arrangement or payments, you may be reported to a credit bureau and denied additional services at Bastyr Center. If this happens, we can help you transfer your care.

Returned Checks

Bastyr charges $28 for any returned checks.

Questions?

Please contact our Billing Office at 206.834.4183, if you have any questions about anything in our policy.

Consent to contact

Acknowledgement of our policies. You consent to being contacted by Bastyr or any organization we may assign your account to.

Signed: ______________________________

Patient Cancellation and No-Show Agreement

BASTYR University CLINIC | YOUR PARTNER IN NATURAL HEALTH CARE

Patient Information

Welcome to Bastyr University Clinic. We are glad you have made an appointment for yourself or a family member.

To provide you with high-quality care, it is important for you to keep your scheduled appointment with the medical provider. Valuable time has been reserved for you or your family member. A missed appointment or late cancellation results in lost time that could have been given to another person wanting to receive care.

- Patients arriving more than 15 minutes late to their appointment will be subject to the providers' discretion as to whether they can be seen. Late arrivals may also be subject to an abbreviated visit.
- If a patient cannot be seen, or is more than 20 minutes late for a scheduled visit, it will automatically be considered a no show.

You will receive a reminder call two days ahead and remind you of your appointment; however, it is your responsibility to keep record of your appointment and to arrive on time. If you need to cancel or reschedule your appointment, please call 24 business hours in advance. You may also leave a message with our scheduling desk. Every late cancel/no-show will be recorded in your chart. Multiple late cancels and no-shows can end your ability to make advance appointments or receive care at Bastyr University Clinic.

We realize that an emergency may occur and/or you may not be able to notify us. We will discuss that situation with you when it happens.

- **After One (1) Late Cancel/No Show: You will be reminded of our Late Cancel/No Show policy.**
- **After Two (2) Late Cancels/No Shows: There will be a charge of $40 for appointments in Team Care, or $60 for appointments in Practitioner Care. (Bastyr Students will be charged $30.)**
- **After Three (3) Late Cancels/No Shows: Advanced scheduling privileges will be suspended for three months. You can still be seen on a same-day scheduling basis only, depending on provider availability. We cannot guarantee that you will be seen.**

Thank you for working with us to ensure that services are provided to all our patients in the best possible way.

Acknowledgement of Cancellation and No-Show Agreement

______________________________ ______________________________
Signature **Date**

______________________________ ______________________________
Print name **Date of birth**

______________________________ ______________________________
Name of patient if minor **Date of birth**

Consent for Treatment

BASTYR University CLINIC

General Information: Bastyr University Clinic is a teaching clinic for students studying at Bastyr University California that includes a Practitioner Care Department, where independent providers rent space from Bastyr to see patients in their private practice. Bastyr University Clinic's teaching clinic uses a "Team Care" approach where faculty supervisors and student clinicians work as a team to address your health concerns. Student clinicians, depending on their levels of experience, may observe or participate in the care provided but are always supervised by health care providers licensed in the State of California. Your medical history, treatment plan and progress is discussed (without identifying information) among other student clinicians for educational purposes at the clinic and evaluated by the supervising faculty for appropriateness and effectiveness. Due to the diversity of modalities offered at Bastyr University Clinic, your treatment may include any or all of the following general modalities: Naturopathic Medicine, Physical Medicine, Homeopathy, Mind-Body Medicine and Nutritional Counseling. Some modalities may be used exclusively on some specialty shifts, but many Bastyr University Clinic teams use multiple treatment modalities.

Please visit www.BastyrClinic.org for individual faculty biographies.

Methods, Procedures and Therapeutic Approaches: Clinicians may perform general diagnostic procedures, psychological counseling, lifestyle counseling, exercise prescriptions, acupuncture, ayurvedic services, topical treatments, herbal medicine, natural medicine, dietary advice and therapeutic nutritional counseling, soft tissue and osseous manipulation, electromagnetic and thermal therapies. See brief description of methods, procedures and approaches.

I understand that California State law does not authorize naturopaths to treat me for any **cancer or malignancy** and that I am required to be under the care of a medical doctor or osteopathic physician (oncologist) while receiving care at the Bastyr University Clinic.

I am currently under the care of ______________________________
I recognize that I am here for supportive therapies only.

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 the Bastyr University Clinic or any of its personnel regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. **I hereby acknowledge that I am financially responsible for services rendered.**

____
Patient's Name (PRINT)

____
Guardian/Personal Representative's Name (PRINT)

____
Patient's Signature

____
Guardian/Personal Representative's Signature

____
Date

____
Relationship/Representative's Authority

Notice of Privacy Practices Acknowledgement Form

BASTYR University CLINIC | YOUR PARTNER IN NATURAL HEALTH CARE

Patient Name: ______________________________ **Date of Birth :** ______/______/______
(please print)

Bastyr University Clinic is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement, if possible, that you have received it. A parent or guardian should sign for patients under age 18. Please return to staff. If you have questions concerning the management of your health care information at our clinic, or if you wish schedule an appointment to view your medical record, please call our medical records office at 858.246.9700.

______________________________ ______________________________
Print Name **Date**

______________________________ ______________________________
Patient/Legal Guardian/Representative's Signature **Date**

____
Relationship to Patient

OFFICE USE ONLY

Staff member's initials: ______________________

☐ I offered the Notice but the patient or patient's representative is unable or refuses.

☐ I have updated the NPP Flag in Epic

☐ Reason ______________________________