Seattle Advanced Thyroid Health

155 NE 100th St. Suite 402
Seattle, WA 98125
Ph: 206-925-3525 Fax: 206-925-3237
info@SeattleAdvancedThyroid.com
www.SeattleAdvancedThyroid.com

Date:_____

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

Address:_____ _____ _____ _____
Street City State Zip Code

Gender: ☐ Male ☐Female Date of Birth: _____/_____/_____ Age:_____
Month Day Year

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

Occupation:_____ Employer:_____

Home Phone:(_____)_____ Work Phone:(_____)_____Ext:_____

Cell Phone:(_____)_____

Primary phone number to reach you by: ☐Home ☐Cell ☐Work ☐ Other _____

Secondary phone number to reach you by: ☐Home ☐Cell ☐Work ☐ Other _____

E-mail to reach you by:_____ ☐OK to send me newsletter & promos
☐ Check if not OK to communicate by email

Emergency Contact:_____ Phone Number:(_____)_____

Relationship to you:_____

How did you hear about us? ☐ Website ☐ Insurance ☐ Friend/Family_____ Other _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

Address:_____ _____ _____ _____
Street City State Zip Code

Primary Insurance Information

Insurance Company:_____ ☐ Check here if you have a secondary insurance

Insurance ID#:_____ Group#:_____

Insurance Subscriber:_____ Subscriber Relationship to you:_____

Gender: ☐Male ☐Female Subscriber Date of Birth:_____/_____/_____
Month Day Year

Provide front & back copy of your insurance card(s) with this intake if using insurance

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize treatment and agree to pay all fees associated with such treatment. I agree that I am financially responsible for all services provided and should it be necessary to refer the account to collections I will be responsible for all collection fees, collection costs, attorney fees and court costs involved with my account. Out of Network patients: My balance is due at the time of service, and I can request a detailed receipt for me to file a claim to my insurance for reimbursement. If a payment plan is needed, I will ask at that time of service. In Network patients: I authorize my insurance benefits to be paid directly to my physician. I authorize my physician to release any information required to process my claim.

TERMS OF ACCEPTANCE

Methods, Procedures, and Therapeutic Approaches*:* The provider may perform any of the following procedures as necessary to give proper assessment, determine treatment approaches, treat or otherwise address my health concerns. I understand that there are intrinsic differences between care received from naturopathic doctors (ND) and medical doctors (MD). Also, I understand that, as with any medical treatment, there is no guarantee that this treatment will offer complete resolution of any or all conditions that I may have.

General Diagnostic Procedures: Including but not limited to blood and urine lab work, radiography, general physical exams, neurological and musculoskeletal assessment.

Herbs/Natural Medicines: Prescribing of various therapeutic substance including plants, minerals, and animal materials. Substances may be given in the form of pills, powder, tincture, topical creams, pastes, suppositories, and other forms. Homeopathic substances may also be used.

Dietary Advice and Therapeutic Nutrition: Use of foods, diet plans or nutritional supplements for treatment-may include intramuscular and vitamin injections. Upon instructions of the physician, I may be referred to a registered dietitian for further nutritional, lifestyle, and exercise consulting where they will work in correlation about my treatment.

Electromagnetic and Thermal Therapies: Includes the use of ultrasound, electrical muscle stimulation, microcurrent stimulation, and infrared therapies.

Notice to Pregnant Women*:* All female patients must alert the doctor if they know or suspect they are pregnant, since some of the therapies could present a risk to the pregnancy.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to diagnostic and treatment options that the provider deems appropriate for my care.

All questions regarding the provider's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept care on this basis, and I agree to the authorization and assignment of benefits and billing and payment.

_____

Print Patient Name

_____ _____

Signature Date

For Minor's Consent:

I hereby authorize Seattle Advanced Thyroid Health to administer treatment as they deem necessary to the patient above.

_____

Print Parent/Guardian Name

_____ _____

Signature of Parent/Guardian Date

Seattle Advanced Thyroid Health Office Policy

Office Visits, Labs, and Supplements-The patient/guarantor is fully responsible for the patient balance at the time of service including, but not limited to, consults, labs, and supplements. Insurance coverage verification is the patient's responsibility. Current credit cards must be on file for initial appointments, phone/video consults, E-Service, and for supplement/lab orders. Lab or supplement orders will be made after receiving payment. Payment is due at the time of service. Seattle Advanced Thyroid Health will be happy to set up payment installments upon patient's request. **Missed and canceled appointments less than 2 business days will be subject to a $100 fee.** Credit cards on file required for initial appointments or patients with at least 2 late cancellation/missed appointments.

E-Visit-Unless a provider requires an appointment, E-Visits set up to expedite a patient request. This service is a single email or portal response that allows the provider to dedicate time needed to review and respond to patient inquiry. Patients can receive answers to their questions without having to wait for an appointment and it is usually less costly than an official appointment. Charges range from $15-$75 for this medical service. If a patient has additional questions after the first response from the provider, he/she should request to get in for a brief and the payment will be credited towards that visit if scheduled within two weeks.

Statements-Bills are generated 15th and 30th of each month, and it will be sent by email, mail, or patient portal. Payments by cards, cash, and checks are accepted. Each late statement is subject to an $8 late fee. Balances over 90 days will be sent to collections. For any questions on statements, contact the front desk before the due date to avoid any late fees. Returned checks are subject to a $25 fee.

Labs-Payment is required at the time of lab orders and lab tests/kits are not refundable. This prepayment will ensure that the patient knows the exact cost of the lab. It is the patient's responsibility to follow the provider's treatment plan to do the test. If a replacement kit is required or a kit needs to be mailed, a $12 fee will apply. An E-Visit or an appointment may be required for the order for the physician to recheck and generate the order.

Lab Result Appointments-In most cases, a follow up appointment is required to discuss results. Unless no discussion needs to be made based on the provider's decision, requests to just send only the results without an appointment will be denied. Providers at Seattle Advanced Thyroid Health analyzes lab results in great detail. This policy is in place to avoid any misinterpretation and to make sure that the patient receives the upmost care for their case. Appointments will usually range from 20-60 minutes depending on the results, number of labs, and number of questions. If results are urgent, the provider will contact the patient immediately by phone and will follow up in more detail at the earliest appointment. All other results will be discussed at the scheduled appointment.

Supplements-Seattle Advanced Thyroid Health carries and recommends only the highest quality of supplements that has been approved by their physicians. Orders placed electronically or by phone will be processed within 1-3 business days and current credit card must be on file. Patient may be required to make an appointment or E-Visit for refill questions asked outside of their office visit. If a letter of medical necessity (LOMN) is needed, please ask at the time of the appointment. The front desk providing copies for LOMN that are already in the patient files are not subject to the charge. LOMN will only be provided for supplements purchased through Seattle Advanced Thyroid Health and for specific brand of supplements that the providers recommended at the office visit.

Pharmacy Prescriptions-Please request refills directly to your pharmacy at least 5 business days in advance. Your pharmacy will contact us directly along with any changes you request. If you need prescription filled at another pharmacy, request the transfer to get the remaining leftover refills to your new pharmacy. If no refills remain, request an E-visit along with the pharmacy name, address, phone, and fax. If the provider requires an office visit to recheck your dose or order any labs, the front desk will notify you.

I understand and agree to the office policy above. I have the right to request the current version at any time as policies can be updated.

Patient Name: _____

Signature:_____ Date:_____

Seattle Advanced Thyroid Health
155 NE 100th St #402, Seattle, WA 98125
Effective Date: April 14th 2003

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notices of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have you any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice Any health care professional authorized to enter information into your medial record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be will be shared.

How We May Use and Disclose Medical Information About You The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situation
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternative or other health-related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your individual Rights Regarding Your Medical Information Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for you care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restriction, you must submit your requesting writing to the Privacy Office at this practice. In your request, you must
tell us what information you want to limit.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decision about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you maybe ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month periods will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes To This Notice We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date on the upper right corner of the first page. I have read and understand this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make change regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Patient Name:_____

Date of Birth:_____/_____/_____

Signature:_____

Date:_____/_____/_____