

Patient Information Form

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 ____ / ____ / ____

Patient Information Form

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

- | | |
|---|--|
| <input type="checkbox"/> Primary management of my health | <input type="checkbox"/> Adjunctive care for my health |
| <input type="checkbox"/> On-going management of my health | <input type="checkbox"/> One time advice for my health |
| <input type="checkbox"/> 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

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 (Initials): _____ Date: _____ / _____ / _____

Financial Agreement

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

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

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

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 _____