Leah McNeill, ND

Ohana Wellness Center
2340 130th Ave NE | Bldg D – Suite 200 | Bellevue, WA 98005

(Please print clearly)

PATIENT INFORMATION

Name: _____ Birth Date: ____ /____ /_____ Sex: M / F

Marital Status (circle one): Single Married Divorced Widowed Separated Domestic Partner

Address: _____ City/State: _____ Zip: _____

• Home Ph: _____ - _____ - _____ • Cell Ph: _____-_____-_____

• Email address (print clearly) _____

In case of emergency, notify: _____

• Home Ph: _____-_____- _____ • Cell Ph:_____-_____-_____

• Relationship to Patient (spouse, father, mother, etc)_____

Referred by:

Primary Care Provider (Dr.'s name):

Insurance Information:

PLEASE WRITE THE NAME OF YOUR INSURANCE CARRIER _____

Your relationship to the Insured (subscriber) on the card: Self / Spouse / Child / other

Insurance Plan name (if applicable) _____

WE NEED TO MAKE A COPY OF YOUR INSURANCE CARD & DRIVER'S LICENSE

By signing below, I declare the information provided above is true and factual.

Patient/Guardian Signature: _____ Today's Date: _____ /____ /_____

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PAYMENT POLICY / CANCELLATION POLICY

It is the patient's responsibility to ensure: 1) their insurance plan covers Naturopathic care and 2) the doctor is contracted in-network provider within their insurance plan. Call the Customer Service Phone # on the back of your insurance card to check your benefits before your first visit.

IF NOT COVERED BY YOUR INSURANCE, PAYMENT IN FULL IS DUE AT THE TIME OF SERVICES.
It is then your responsibility to submit claims to your insurance plan for reimbursement of the office fees. This office and your insurance card/company will provide you with the information necessary. Secondary insurance company billing is the patient's responsibility unless doctor is contracted with the secondary insurance company.

What are my Lab benefits? Some of the labs used by the doctor include: LabCorp and Diagnos-Techs, Inc.
Some labs offer discounts for prepaid labs if no insurance coverage.
It is your responsibility to find out if your insurance is contracted for lab work ordered by the doctor.

I understand that all lab test fees are determined by the lab, and if not covered by patient's insurance, becomes the responsibility of the patient.

IT IS YOUR RESPONSIBILITY TO KNOW THE TERMS OF YOUR COVERAGE FOR EACH VISIT INCLUDING:

1. Whether Naturopathic services are covered and whether doctor is contracted in-network provider for plan
2. If there is a deductible to meet first.
3. If a referral is required from your primary care provider? If yes, it is your responsibility to obtain the referral and provide our office with a referral number before your appointment.
4. If you have a co-payment, it is due at the time of services.
5. If lab tests are covered – both the test itself and the facility used are separate practices and bill separately. It is your responsibility to give your insurance info to the labs.

- **We require at least 24-hour notice from you for an appointment cancellation or rescheduling. Failure to do so may incur $65.00 cancellation fee or missed appointment fee up to the cost of the scheduled visit.**
- **Arrival by a patient 15 minutes or more after scheduled appointment time may result in cancellation of the appointment and patient may incur a missed appointment fee of $65.00 up to the cost of the scheduled visit.**
- **Patient understands that a cancellation fee or missed appointment fee is not covered by insurance and payment is the sole responsibility of the patient or guardian in the case of a minor and the fee may be charged to card on file.**

Telehealth is healthcare provided by any means other than a face-to-face visit. In Telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, video conferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered Telehealth services.

• I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology assisted format.

• I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carriers, and it is my responsibility to check with my insurance plan to determine coverage.

• I understand if Telehealth is not covered by my health plan, I am responsible for the payment.

• I understand that it is clinic policy for patients opting into telehealth visits to have a debit, credit, or HSA card on file. The clinic will charge insurance co-pay, co-insurance, deductible or private pay total. We will send an email receipt upon charge.

• It is my responsibility to make sure payment options for telehealth are up to date and will notify the office of any payment changes.

• I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations-including further diagnostic testing, lab testing, biopsy, or in-office visit.

PAYMENT POLICY / CANCELLATION POLICY (continued)

YOU ARE DIRECTLY RESPONSIBLE FOR PAYMENT OF ALL CHARGES INCURRED UNDER OUR CARE.

All Pharmacy items are to be paid for when they are received.
We accept payment by cash, check, Visa, and MasterCard
We charge $35.00 for returned checks.
We charge $10.00 fee/month for patient balance portion not paid within 30 days. Delinquent accounts may be sent to a Collections Service for collection.

- I understand that I am responsible for my account balance with Ohana Wellness Center doctors, and account balances may be paid with my card on file.
- I understand that certain procedures (e.g; Myers infusion, etc) may not be covered by your insurance and I understand in such cases, if payment is denied by insurance, I am responsible for payment of such received procedures.
- I authorize release of information to all my insurance companies if requested.
- I authorize my doctor to help me obtain payment from my Insurance if she is contracted.
- I authorize payment direct to my doctor from my Insurance.
- I understand that I am responsible for my account balance with facility used for any lab work.
- I permit a copy of this authorization to be used in place of the original.

I understand and agree to the above policy. I will abide by its terms.

Name (printed): _____ **Date:** _____

Signature (parent/guardian if minor) _____

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Acknowledgment of Receipt of Privacy Practices (HIPPA)

I, (**print name**) _____, patient of the above-mentioned provider, do hereby acknowledge receipt/offer of a **copy** of this provider's Notice of Privacy Practices.

Signature: _____ Date:

Authorization to Leave Personal Health Information by Alternate Means:

Please check all that apply:

May send an email message:	_____	
	Email address	
May leave a detailed message on voicemail at home:	_____	
	Home phone number	
May leave a detailed message on voicemail at work:	_____	
	Work phone number	
May leave a detailed message on cell phone:	_____	
	Cellular phone number	
May leave a detailed message at different location:	_____	
	Phone number & location	
May leave a detailed message with spouse/partner:	_____	
	Name of spouse/partner	phone #
May leave a detailed message with other family member:	_____	
	Name & relationship	phone #

By signing below, I understand and acknowledge that this information will be kept in my medical record and the above information will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

Signature: _____ Date:

HEALTH HISTORY

Dr. Leah McNeill
2340 130th Ave NE, Suite D-200
Bellevue, WA 98005 (P) 425-881-2310

PATIENT NAME: _____
BIRTHDATE: ____/____/_____ **AGE:**_____ **SEX: M F**

This history form provides us with information to help us meet your healthcare needs. Please answer each question as thoroughly as possible. ***This is a confidential part of your medical record.***

Today's date _____

Place of birth _____

Highest level in school _____

Occupation _____

Previous occupations _____

Hobbies _____

Exercise/recreation _____

Smoking (type & amount per day) _____

If former smoker, date quit _____

Alcohol (type & amount per week) _____

Caffeine (type & amount per day) _____

Recreational drugs (type & amount per day) _____

Height_____ Weight_____

Date of last dental exam _____

Please list all allergies (foods, drugs, environment) and allergic reactions to each (hives, difficulty breathing, etc.)

_____

_____

_____

When was your last physical exam?_____

Name of doctor_____

Please list all serious illnesses, injuries, operations, and hospitalizations you have experienced (include year occurred):

_____

_____

_____

_____

Please list any **prescription drugs** you are currently taking and dosage:

_____

_____

_____

_____

Please list any **nonprescription drugs and supplements** you are currently taking and dosage:

_____

_____

_____

_____

_____

REASON FOR TODAY'S VISIT

Please list why you are seeking care and (in order of importance) the health concerns, symptoms, or problems you are experiencing:

_____

_____

Women only:

- Age period began_____
- Date of last pelvic exam_____
- Date of last mammogram_____
- Date of last period_____
- # of days period lasts_____
- Days between periods_____

- Do you have pain or cramps? Yes No Sometimes
- Any itching in the vaginal area? Yes No Sometimes
- Do you bleed or spot between periods? Yes No Sometimes
- Is your flow heavy? Yes No Sometimes
- Pain with intercourse? Yes No Sometimes

- Type of birth control used_____
- Number of pregnancies _____
- Number of full term births _____
- Number of preterm births_____

HEALTH HISTORY

Dr. Leah McNeill
2340 130th Ave NE, Suite D-200
Bellevue, WA 98005 (P) 425-881-2310

PATIENT NAME: _____

MEDICAL HISTORY

Have you ever had the following: (Circle "no" or "yes" or leave blank if uncertain)

•Measles	no | yes	•Bronchitis	no | yes	•Kidney disease	no | yes
•Mumps	no | yes	•Asthma	no | yes	•Urinary tract infection	no | yes
•Chickenpox	no | yes	•Hives/Eczema	no | yes	•Hernia	no | yes
•Whooping cough	no | yes	•Thyroid disease	no | yes	•Hemorrhoids	no | yes
•Scarlet fever	no | yes	•Diabetes	no | yes	•AIDS or HIV+	no | yes
•Pneumonia	no | yes	•Heart disease	no | yes	•STDs	no | yes
•Tuberculosis	no | yes	•Stroke	no | yes	•Substance abuse	no | yes
•Date of last chest x-ray_____		•Mitral valve prolapse	no | yes	•Blood transfusion	no | yes
•Infectious mono	no | yes	•High blood pressure	no | yes	•Bleeding tendency	no | yes
•Meningitis	no | yes	•Low blood pressure	no | yes	•Other (Please list)	
•Anemia	no | yes	•Arthritis	no | yes	_____	
•Cancer	no | yes	•Osteoporosis	no | yes	_____	
•Epilepsy	no | yes	•Hepatitis	no | yes		
•Migraine headaches	no | yes	•Ulcer	no | yes		
•Glaucoma	no | yes	•Bowel disease	no | yes		

FAMILY HISTORY

Has any blood relative had any of the following: (Circle "no" or "yes" or leave blank if uncertain)

	Relationship		Relationship
•Cancer	no | yes_____	•Depression	no | yes_____
•Tuberculosis	no | yes_____	•Psychosis	no | yes_____
•Diabetes	no | yes_____	•Suicide	no | yes_____
•Heart disease	no | yes_____	•Leukemia	no | yes_____
•High blood pressure	no | yes_____	•Migraine headaches	no | yes_____
•Stroke	no | yes_____	•Obesity	no | yes_____
•Epilepsy	no | yes_____	•Thyroid disease	no | yes_____
•Allergies	no | yes_____	•Ulcer	no | yes_____
•Anemia	no | yes_____	•High cholesterol	no | yes_____
•Bleeding tendency	no | yes_____	•Kidney disease	no | yes_____
•Asthma	no | yes_____	•Glaucoma	no | yes_____
•Chronic lung disease	no | yes_____	•Gout	no | yes_____
•Substance abuse	no | yes_____	•Other:	_____

List the present age or the age of death of each of the following members of your family. If living, add whether their health is "good," "fair," or "poor." If deceased, list the cause of death.

Father_____ Brother(s)_____

Mother_____ Sister(s)_____

Spouse_____ Son(s)_____

Daughter(s)_____

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HEALTH HISTORY

PATIENT NAME: _____

SYMPTOM SURVEY

Use the scale below to evaluate any symptoms you have experienced within the last six (6) months.

SCALE OF SYMPTOM POINTS:

0 = NEVER or almost never
1 = OCCASIONALLY (less than 2 times per week), not severe
2 = FREQUENTLY (2 or more times per week), not severe
3 = OCCASIONALLY and is severe
4 = FREQUENTLY and is severe

CONSTITUTIONAL
_____ Fever
_____ Night sweats
_____ Fatigue (sluggish, tired)
_____ Sleepiness during day
_____ Insomnia
_____ Dizziness
_____ Shortness of breath

EMOTIONAL/MENTAL
_____ Depression
_____ Anxiety
_____ Mood swings
_____ Irritability
_____ Forgetfulness

SKIN
_____ Acne
_____ Rashes, hives
_____ Eczema
_____ Bruise easily

HEAD
_____ Headache
_____ Hair loss
_____ Ear problems
_____ Ringing in ear
_____ Post-nasal drip
_____ Sinus pain
_____ Runny/stuffy nose
_____ Sneezing

MUSCULOSKELETAL
_____ Joint pains/aching
_____ Stiff joints
_____ Muscle pain
_____ Muscle cramps
_____ Arthritis

URINARY
_____ Pain during urination
_____ Frequent urination
_____ Blood in urine
_____ Incontinence

CARDIOVASCULAR
_____ Chest pain
_____ Irregular heartbeat/palpitations
_____ High blood pressure

DIGESTIVE
_____ Heartburn/reflux
_____ Abdominal pains/cramps
_____ Constipation
_____ Diarrhea
_____ Gas/bloating
_____ Nausea
_____ Vomiting
_____ Painful elimination

OTHER
_____ Restless legs
_____ Feet get cold or numb
_____ Legs hurt walking a lot
_____ Sores on legs not healing
_____ Tingling in the legs

Describe what you typically eat each day:

Breakfast:_____

_____

Lunch:_____

_____

Dinner:_____

_____

Snacks:_____

_____

Fluid intake (water, tea, juice, etc.):

_____

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HEALTH HISTORY

PATIENT NAME: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary health care services I may need.

Patient Signature_____ Date_____

Physician's comment

Physician's Signature_____