Leah McNeill, ND

Ohana Wellness Center
2340 130th Ave NE | Suite D-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: _____-_____-_____ • Work Ph:_____-_____-_____ • Cell Ph: _____-_____-_____

• Email address (print clearly) _____

In case of emergency, notify: _____

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

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

Employer: _____ 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_____

Name of Insured (subscriber): _____ Birth Date of Insured: ____ /____ /_____

Employer of Insured: _____

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: _____ /_____ /_____

Acknowledgment of Receipt of Privacy Practices (HIPPA)

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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:** _____

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

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, Diagnos-Techs, Inc. and Genova
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 a 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 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.**

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 either insurance co-pay or private pay total, and 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) _____

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

PEDIATRIC HEALTH HISTORY

PATIENT NAME: _____

Confidential Pediatric Intake form to be filled out by parent or legal guardian

TODAY'S DATE: **DATE OF BIRTH:**

CHILD'S FULL NAME: **AGE:**

PREFERS TO BE CALLED: **SEX: M F**

Date of last complete check up: **HEIGHT:** **WEIGHT:**

Reason for visit
What brings you in for this initial visit? If a diagnosis was made, please indicate date of diagnosis and who or where it was diagnosed.

Are there any areas you would like to work on?

How would you rate the general health of your child: (1 being poor; 10 being excellent):

Is your child on any medications, homeopathics, or supplements (including vitamins and herbs)? (Please list dosages)

Any allergies to medications?

Allergies to other substances (foods, environmental, etc)

Any problems during pregnancy or birth?

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PATIENT NAME: _____

Any difficulties for child following birth?

Has your child experienced any major childhood illnesses, accidents, hospitalizations or surgeries? (Please include dates and child's age at the time)

Immunizations and date if known

DTP Yes No When:

Polio Yes No When:

MMR Yes No When:

Hepatitis B Yes No When:

HbCV Yes No When:

Chickenpox Yes No When:

Other

Siblings

Name	Age	General Health:		
		Poor	Fair	Good

What are some of your child's favorite activities/hobbies?

Does your child have any fears?

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PATIENT NAME: _____

What are your child's favorite foods and how often are they eaten?

What type of pets do you have?

Does anyone in the house smoke? Yes No

How many hours of TV and video/computer games does your child engage in daily?

How would you rate your child's academic performance? (if appropriate)

Poor Fair Good Excellent

Is there anything else you feel we should know about your child?

Family History: check all that apply and indicate family member's relation to you (i.e.; maternal aunt). If family member has passed away from any of the following, please indicate their approximate age at the time of their passing.

- ☐ Diabetes
- ☐ Heart disease
- ☐ Stroke
- ☐ Heart attack
- ☐ Thyroid disorders
- ☐ Alzheimer's disease
- ☐ Hypertension
- ☐ High cholesterol
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Depression
- ☐ Alcoholism
- ☐ Cancer (type)
- ☐ Other neurological disease (indicate)
- ☐ Chronic gastrointestinal disease (i.e.; Crohn's disease, ulcerative colitis, peptic ulcers, reflux)
- ☐ Emphysema (or other chronic respiratory disorder)
- ☐ Chronic skin condition (i.e.; Psoriasis, eczema, rosacea)

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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 child's health. It is my responsibility to inform the doctor's office of any changes in my child's medical status. I also authorize the healthcare staff to perform the necessary health care services my child may need.

Parent/Guardian Signature_____Date_____

Physician's comment

Physician's Signature_____