CONFIDENTIAL PATIENT INFORMATION

Evergreen Center FOR
Integrative Medicine

2008 NE 65th St
Seattle, WA 98115
(206) 729-0907

❑ Dr. Bobbi Lutack
❑ Dr. Traci Taggart
❑ Dr. Terra Winston

Patient Information	First Name:	MI:	Last Name:
Street Address:			
City:	State:		Zip:
SSN:	Gender: ❑ M ❑ F		Home phone:
Date of Birth (mm/dd/yyyy): / /	Age:		Alt phone: ( )
Email Address:			
Employment: ❑ Employed ❑ F/T Student ❑ P/T Student ❑ Retired ❑ Other			
Employer:			Work phone: ( )
Marital Status: ❑ Single ❑ Married ❑ Partnered ❑ Divorced ❑ Widowed ❑ Dependent ❑ Other			
❑ Parent ❑ Guardian ❑ Spouse ❑ Partner Phone: ( )			
Emergency Contact:	Relationship:		Phone: ( )
Who referred you to us?			

Primary Health Insurance	Insurance Company Name:	Phone: ( )
Claims address:		
Name of Insured:		Insured's DOB: / /
Relationship to you: ❑ Self ❑ Parent ❑ Spouse ❑ Dependent ❑ Other:		
ID # on card:		Group #:
Employer of insured:		

Secondary Insurance, AUTO or L&I:	Insurance Company Name:	Phone: ( )
Is this visit injury-related? ❑ yes ❑ no Work-related? ❑ yes ❑ no Auto Accident? ❑ yes ❑ no If yes, State:		
Claims address:		
City: State: Zip:	Adjuster's Name (if known):	
Name of Insured:		Insured's DOB: / /
Relationship to you: ❑ Self ❑ Parent ❑ Spouse ❑ Dependent ❑ Other:		
Claim # or ID #:	Policy # (Auto) or Group #:	
Injury Date / Effective Date: / /	Employer of Insured:	

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assessed a fee. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician. ***Please note that all the doctors at ECIM are sole proprietors.***

Signature _____ Date _____

PEDIATRIC HISTORY	Provide general description and dates for the following (to the best of your knowledge)

Born In: ❑ Hospital ❑ Clinic ❑ Home ❑ Other

Method: _____

List **present** symptoms. List most important first:

Vaccinations:

Operations:

Serious Illnesses:

Medicines taken in last 5 years (include date and duration for major medicines - e.g. Amoxicillin, 3 mos., repeated ear infections 2/97):

Current medications:

Date of last checkup:	Doctor's Name & Phone:		
Birth weight: lbs ounces	Length: inches	Chest:	Head:

List any chemicals, metals, dusts, smoke or fumes your child is repeatedly exposed to:

Does your child react to pollens? If so, which ones?

Does your child react to foods? If so, which ones?

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PEDIATRIC HISTORY — Provide general description and dates for the following (to the best of your knowledge)

If your child HAS or DID HAVE any of the following, please check:

- ❑ Attention Deficit Disorder
- ❑ Colic
- ❑ Eczema
- ❑ Excess Fatigue
- ❑ Frequent Cough/Wheezing
- ❑ Frequent Infections
- ❑ Hyperactivity
- ❑ Insomnia
- ❑ Learning Difficulties
- ❑ Other: _____

FAMILY HISTORY — If family members have had any of the following, please check:

- ❑ Allergies
- ❑ Alcoholism
- ❑ Asthma
- ❑ Bleeding Tendency
- ❑ Blindness
- ❑ Cancer
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Hypoglycemia
- ❑ Kidney Disease
- ❑ Nervous or Mental Disorder
- ❑ Obesity
- ❑ Tuberculosis
- ❑ Other:_____

Which of the above does your child have, if any?

HABITS — Circle appropriate answer below

Milk / Formula:	never	rarely	frequently	weekly	daily:	once a day	twice a day	3x / day	4x / day	5+x / day
Mother's Milk:	never	rarely	frequently	weekly	daily:	once a day	twice a day	3x / day	4x / day	5+x / day
Sugars/Sweets:	never	rarely	frequently	weekly	daily:	once a day	twice a day	3x / day	4x / day	5+x / day
Fruit Sweeteners:	never	rarely	frequently	weekly	daily:	once a day	twice a day	3x / day	4x / day	5+x / day
Fast Food:	never	rarely	frequently	weekly	daily:	once a day	twice a day	3x / day	4x / day	5+x / day
Protein Foods:	never	rarely	frequently	weekly	daily:	once a day	twice a day	3x / day	4x / day	5+x / day
Vitamins / Minerals:	never	rarely	frequently	weekly	daily:	once a day	twice a day	3x / day	4x / day	5+x / day
Aspirin:	never	rarely	frequently	weekly	daily:	once a day	twice a day	3x / day	4x / day	5+x / day
Laxatives:	never	rarely	frequently	weekly	daily:	once a day	twice a day	3x / day	4x / day	5+x / day

Does your child eat a special diet?

What are your child's favorite foods?

What is your child's general disposition?

How much does your child sleep?

Does your child wear (circle): cloth diapers disposable none

GENERAL

Are you willing to change your habits to help improve your child's health?

Does your child have any other problems you would like to discuss with the doctor?

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CONSENT FOR TREATMENT

Methods, Procedures, and Therapeutic approaches: Your physician may perform any of the following procedures as necessary to give proper assessments,determine treatment approaches, treat, or otherwise address your health concerns.

General Diagnostic Procedures: Including but not limited to venipuncture, pap smears, radiology, blood and urine lab work, general physical exams, neurological and musculoskeletal assessments.

Psychological and Lifestyle Counseling, Exercise Prescriptions

Herbs/Natural Medicine: Prescribing of various therapeutic substances including plants, minerals, and animal materials. Substances may be given in the form of teas, pills, powders, and tinctures (which may contain alcohol) topical creams, pastes, plaster washes, suppositories or other forms. Homeopathic remedies (often highly diluted quantities of a naturally occurring substance)may also be used.

Dietary Advice and Therapeutic Nutrition: The use of foods, diet plans, or nutritional supplements for treatment. This may include intramuscular vitamin injections.

Soft Tissue and Osseous Manipulation: The use of massage, neuro-muscular techniques, muscle-energy stretching or visceral manipulations of the extremities and spine including traction and craniosacral therapy.

Potential Risks: May include pain, discomfort, discolorations, infection, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat.or frictional therapies, allergic reactions to prescribed herbs or supplements, soft tissue or bone injury from physical manipulations, and aggravation of pre-existing symptoms or conditions.

Potential Benefits: Restoration of health and the body's maximum functional capacity, relief of pain,and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

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

Statement of Consent For Treatment:

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 participating in these procedures at any given time. With this knowledge,I voluntarily consent to the above procedures, realizing and acknowledging that no guarantees have been given to me by my doctor/practitioner or any of their personnel regarding cure or improvement of my condition(s). I understand that a record will be kept of the health services provided. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or as otherwise permitted by law.

Guardian/PatientsName(print)	Guardian/Patients Signature	Date

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PATIENT-PRACTITIONER RELATIONSHIP

I understand that I am a patient of_____, who is an independent practitioner at The Evergreen Center for Integrative Medicine. The Evergreen Center is not a group practice, but rather a facility where independent practitioners share office space. I understand that my medical care is the sole responsibility of the individual practitioner, not The Evergreen Center for Integrative Medicine or any of the other practitioners who may practice there.

If I am seeing more than one practitioner at this clinic, I understand that each practitioner is required to keep separate records and will be billing for services separately from any other practitioners at this clinic.

_____ _____

Patient Name (please print) Date

_____ _____

Patient/Guardian Signature Relationship to Patient

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NOTICE OF PRIVACY PRACTICES

The Evergreen Center for Integrative Medicine (ECIM) is required to provide you with a copy of its "Notice of Privacy Practices" document and to obtain written acknowledgement, if possible, that you have received it. This notice outlines the types of uses and disclosures that may occur involving your protected health information. It also describes your rights and explains how you may exercise those rights.

I understand that my protected health information can and will be used to:
* Provide and coordinate my treatment
* Obtain payment from third-party payers for my health care services
* Conduct normal health care operations such as quality assessment and improvement activities

I understand that my provider has the right to change the Notice of Privacy Practices and that I may request a current copy.

My signature below acknowledges that I have (please check one):

_____ been offered a copy of the Notice of Privacy Practices document and have accepted that copy.

_____ been offered a copy of the Notice of Privacy Practices document and have declined a copy. I understand that I can request a copy at any time in the future, and be given a current copy.

_____	_____	_____
Patient/Guardian Signature	Relationship to Patient	Date

Office Use Only

I hereby affirm that ECIM has made a good faith effort to provide a copy of the Notice of Privacy Practices to the above named patient and to obtain written acknowledgement of such.

Staff Initials: _____
Staff please check one:

_____ Pt offered but refused to sign _____ Pt. physically unable to sign

_____ Communication barrier / other reason: _____

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ECIM General Office Policies

Evergreen Center for Integrative Medicine is looking forward to helping you to achieve your health goals. To ensure this, we would like to present some general policies. It is important that you are willing to do all you need to do to get well and you must play an active role in your health care for optimal results.

1. Keep regular follow-up appointments (every 4-8 weeks if on treatment protocols) We cannot be responsible for your care without this continuity. Phone appointments may be arranged for some of your visits, but we will not go longer than 12 weeks without seeing you in office. Physically being present allows us to provide better care. Medications may not be refilled if you have failed to schedule/ follow up in a timely manner.

2. Time is limited during your visit, and we ask that you come organized to appointments. We suggest having a written list of questions and/or concerns. Time may not permit addressing all of them, in which case another appointment will need to be made.

3. As many health issues are complex and occasionally can take more time than expected to manage, if a visit extends beyond the allotted time, the additional time will be billed to your insurance or result in an additional fee for self-pay patients. The physician or office staff is unable to notify patients prior as it is difficult to assess each patient's needs before the beginning of a visit or while actively managing a visit.

4. Missed follow up appointments will result in a full appointment charge if they are not cancelled within **2 business days** of the original appointment. This fee cannot be waived and must be paid before another appointment will be made. New patients must cancel or reschedule your visit within **3 business days** of your scheduled appointment to avoid full charge of the appointment. Repeatedly missing, rescheduling or being chronically late to appointments may result in dismissal from the practice.

5. **Do not reply to the reminder email/text. Any cancellations left anywhere besides with/ on the front desk voicemail will be considered a no show/late cancellation. You are responsible for remembering your appointment.** Reminder emails/texts are a courtesy and you are responsible for showing up for scheduled appointments whether you received one or not

6. Treatment changes, including altering current or future protocols and medications for existing or new prescriptions, are often complicated and may require an appointment.

7. Patients receive better care when management is not done via email, the availability of email management is limited. Emails that are simple and require brief clarification (1-2 sentence response to clarify or confirm) may be answered if it is regarding a current protocol. If it involves changing protocols, new or changing condition or requires review of the medical chart you may be asked to make an appointment. The physician may charge for email management.

8. If you need prescriptions refilled, please contact your pharmacy and ask them to fax a refill request and allow up to 2 business days for these to be returned.

9. Your office visit is for your care only. We will not discuss family members or friends' symptoms or treatments during your visit. If other individuals need medical care, they will need to make an appointment.

I have read and understand the above office policies.

Patients Name/Legal Guardian:_____

Patient/Legal Guardian Signature:_____ Date:_____