TREE of HEALTH
INTEGRATIVE MEDICINE

Integrative Cancer Care Intake Form
Patient Information

Last Name: _____First Name: _____ MI: _____

Date of Birth: _____ Sex: _____Gender: ____Other names/Nickname: _____

Address: _____ Apt: _____

City: _____State: _____ Zip: _____E-mail: _____

Home phone: _____ Work phone: _____ Cell phone:

_____ Would you like to receive our clinic newsletter via email? Yes_____ No_____

Marital status (Circle one): Single Married Long-Term Partner Divorced Separated Widowed

Occupation: _____ Employer/School: _____

Mother's Name (minors only): _____

Father's Name (minors only): _____

Emergency Contact: _____Contact's Phone #: _____

Emergency Contact is my: (specify relationship) _____

Family Physician: _____ Phone number: _____

Additional Providers _____

How did you hear about us? (Circle One): Friend Family Medical Referral Newspaper Brochure Flyer Website Insurance Co.

Other_____

Insurance/Guarantor Information

Primary Insurance Company & Plan Name: _____ID Number:_____

Group/Policy Number:_____Name of Policy Holder:

_____ Policy Holder's Date of Birth: _____Policy Holder's

Employer_____ Policy Holder's Gender_____The policy holder is my:

_____ (specify relationship) Secondary Insurance Company & Plan Name:

_____ID Number:_____ Group/Policy

Number:_____Name of Policy Holder: _____ Policy

Holder's Date of Birth: _____Policy Holder's Employer_____ Policy

Holder's Gender_____ The policy holder is my: _____ (specify relationship)

Guarantor Information: (If someone other than the patient is responsible for patient's account)

Last Name: _____First Name: _____ MI: _____

Address: _____ Apt: _____

City: _____State: _____ Zip: _____Phone: _____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and

X That ~~I am subject to all financial terms listed below.~~ _____ _____

Guarantor's Signature Date

Financial Policy and Authorization to Bill Insurance

- Each patient should check with Member Services of their insurance plan to understand their specific benefits. **Our clinic does not verify benefits on your behalf.** You may use the Insurance Benefits Verification form located on page 13 of this packet to call your insurance plan and bring it to your appointment. Patients not utilizing insurance will be asked for payment at the time of their appointment. **Initial** _____

- I understand that if I am providing insurance billing information that I am responsible for all charges whether or not they are covered by my insurance. **Initial** _____

- Co-pays and charges for dispensary items are due at the time of the visit.

- I understand that there is a cancellation policy and that I will be billed $65.00 for missed acupuncture appointments, $100.00 for missed naturopathic appointments, or appointments cancelled with less than 24 hours notice. **Initial** _____

- Phone calls are usually not a covered service by the insurance companies and will incur the same fees as the office visits depending on the complexity. You will not charged for the phone call if you are calling with a clarification question on your current treatment plan or if the doctor has asked you to call.

- I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month.

- I understand that any guarantor who is financially responsible for my account is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.

- I understand that some third-party payers (insurances) may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Tree of Health Integrative Medicine to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

X _____ _____
Patient's Signature Date

X _____ _____
Guardian/Representative's Signature and Relationship Date

Privacy Policy

- We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so.

- Tree of Health Integrative Medicine, PLLC is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have received it. You can read it on our website and receive a copy in our office. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish schedule an appointment to view your medical record, please contact Eleonora Naydis, ND, LAc at (425) 408-0040.

- I hereby acknowledge that I have received a copy of Tree of Health Integrative Medicine's Notice of Privacy Practices. Should I fail to sign this form, I acknowledge that Tree of Health Integrative Medicine has made a good faith effort to obtain my acknowledgement.

X _____ _____
Patient's Signature Date

X _____ _____
Guardian/Representative's Signature and Relationship Date

Information Release Authorization

Ok to leave a message with confidential information on the following voicemails:

____ Home _____Cell ____Work

The following individuals are allowed to obtain information regarding my medical care:

Name _____ Relationship_____

Name _____ Relationship_____

Name _____ Relationship_____

X _____ _____
Patient's Signature Date

X _____ _____
Guardian/Representative's Signature and Relationship Date

Consent for Treatment

I, the undersigned, hereby authorize the following healthcare providers to perform specific procedures within their scope of practice, as necessary to facilitate my diagnosis and treatment: Eleonora Naydis, ND, LAc. (MSA 6/2004 from Bastyr University, acupuncture license # AC00002557), Allison Apfelbaum ND, LMP, Peiwen Wang Fannin, MSAOM Bastyr University, acupuncture license # AC61005822), and Kristen Mattisson, EAMP, LAc, LMP (MSAOM from Bastyr University, acupuncture license # AC60248797).

General Diagnostic Procedures, which may include but not limited to venipuncture, pap smears, radiography, and blood and urine lab work, general physical exams, neurological and musculoskeletal assessments.

Lifestyle Counseling and Hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, immunization, psychological counseling, and balancing of work and social activities.

Dietary Advice and Therapeutic Nutrition: use of foods, diet plans or nutritional supplements for treatment.

Injection/intravenous therapies: Intramuscular vitamin injections, trigger point injections, biopuncture, and intravenous therapies.

Herbs/Medicines: prescribing various therapeutic substances including plants, minerals, animal materials, and some pharmaceuticals, and contraceptive devices. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical creams, pastes, plasters, washes, suppositories or other forms.

Soft Tissue and Osseous Manipulation: use of massage, cupping (a technique to relieve symptoms in which cups made of glass or other materials are placed on the skin with a vacuum created by heat or other device), gua sha (a rubbing on an area of the body with a blunt, round instrument), neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy.

Homeopathic Remedies: use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.

Minor office procedures: e.g., dressing a wound, ear cleansing, care of superficial lacerations, removal of warts/ superficial lesions.

Electromagnetic and Thermal Therapies, which may include the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, infrared and ultraviolet therapies, moxibustion (burning on an acupoint using stick, string, or ball moxa) and hydrotherapy.

Acupuncture: insertion of special sterilized needles through the skin into underlying tissues at specific points on the surface of the body. Sometimes electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians may be used

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: Discomfort, pain, minor bruising, infection, blistering, broken needle, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements, soft tissue or bone injury from physical manipulations, temporary discoloration of the skin, temporary dizziness and lightheadedness, and aggravation of pre-existing symptoms.

Potential benefits: Drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem and the strengthening of the constitution, restoration of health and the body's maximal 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: Labor-stimulating acupuncture points are not used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care or pre-natal care provider authorizing or recommending such a treatment. All female patients must alert the practitioner right away if they know or suspect they are pregnant.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by doctors at Tree of Health Integrative Medicine regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or if it is required or permitted by applicable law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last treatment. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of their ability.

_____	_____
Patient's Name (Print)	Guardian's Name (Print)
_____	_____
Patient's Signature	Guardian's Signature
_____	_____
Date	Relationship to Patient

Tree of Health Integrative Medicine, PLLC
Eleonora Naydis, N.D., L.Ac., FABNO
17311 135th Ave NE, Suite A-250
Woodinville, WA 98072
P: (425) 408-0040; F: (425) 408-0571

Naturopathic Treatment of Malignancy Consent Form

In accordance with the Washington state licensing law of naturopathy, naturopathic doctors may treat malignancy only in concert with an M.D. or D.O.

I, (patient's name) _____, request naturopathic care at Tree of Health Integrative Medicine. An oncologist has diagnosed me with (type of cancer) _____ cancer. I am currently under the care of Dr. _____ (M.D. or D.O.) for my cancer. I understand that Washington law requires that any naturopathic care that I receive at the Tree of Health Integrative Medicine for the treatment of cancer be rendered in concert with a medical or osteopathic doctor.

My signature below attests to my understanding of this important relationship between my health care professionals and my commitment to cooperate with my care providers in this collaborative treatment.

_____	_____
Patient's Name (Print)	Guardian's Name (Print)
_____	_____
Patient's Signature	Guardian's Signature
_____	_____
Date	Relationship to Patient

Tree of Health Integrative Medicine, PLLC
17311 135th Ave NE, Suite A-250,
Woodinville, WA 98072
Phone: (425) 408-0040

Confidential Health Questionnaire

Name (Last, First) _____ DOB_____

Please, fill out the following information as accurately as possible. This information will help the doctor with diagnosis and treatment plan.

Please, list specific health concerns in the order of importance to you:

Health concern	Date started	Diagnosis given	Treatments received

Cancer diagnosis and treatment history

Date of initial diagnosis: _____Type of tumor: _____Your current status (circle one): remission active cancer

Any subsequent diagnoses/metastases with dates: _____

_____

Cancer treatment history and your health care team:

Surgery types and dates: _____

_____

Surgeon: _____ Phone number: _____

Radiation therapy types and dates: _____

_____

Radiation oncologist: _____ Phone number: _____

Chemotherapy treatment types and dates: _____

_____

Additional treatments types and dates: _____

_____

Medical oncologist: _____ Phone number: _____

Primary care physician: _____ Phone number: _____

Additional health care providers participating in your care:

Name: _____ Phone number: _____

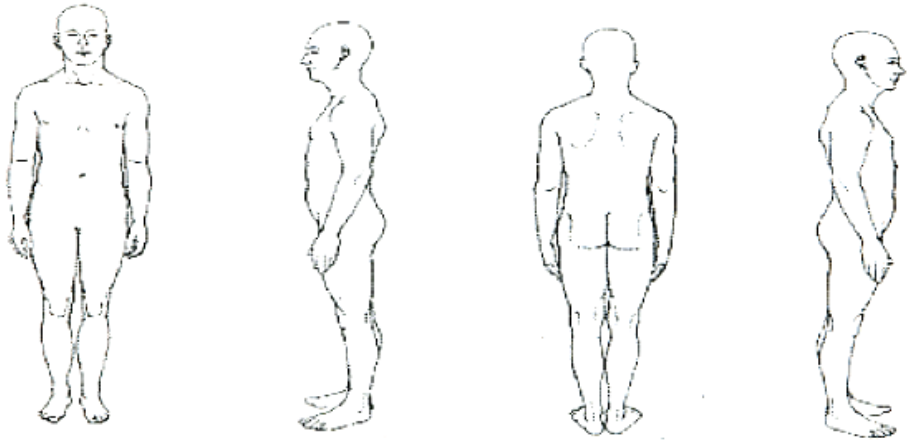
Name: _____ Phone number: _____

Name: _____ Phone number: _____

Your health goals: _____

_____

Please, draw the location of your discomfort:



Please, list all prescription medications, over-the-counter medications, and supplements you are taking:

Medication, OTC, or Supplement	Dosage	Taking for	Doctor (if prescribed)

Are you allergic to any medications, foods, or environmental factors? Please, specify reaction.

_____

_____

List any additional hospitalizations & surgeries Date Place

_____

_____

_____

_____

_____

Date of last physical exam_____ Date of last blood work _____Date of last dental exam_____

Energy level: Please, rate on scale 1-10 (10 highest) _____What time of the day is best? _____ Worst? _____

Stress: Please, rate on scale 1-10 (10 highest) _____ How do you manage stress _____

_____

Work: Do you currently work? _____ Do you enjoy your job? _____ Hours worked per week: _____ Hobbies: _____

Sleep: How many hours per night? _____ Difficulty falling or maintaining sleep? _____ Do you wake up rested? _____

Do you have any dietary restrictions? (Specify)_____

How much water do you drink a day _____Do you exercise? _____How often? _____

What type of exercise? _____

Do you do any form of deep relaxation? _____ What kind?_____

Do you feel you have good social support (friends, family, counselor, etc?) _____

Habits	Now or past	How much	For how long	When did you stop	Would like help with quitting/reducing
Tobacco					
Alcohol					
Caffeine					
Soda					
Recreational drugs					

24 hour diet recall: (please record food and drink you have had within past 24 hours). Please, indicate the time of your meal

Breakfast:_____

_____

Lunch:_____

_____

Dinner:_____

_____

Snacks_____

_____

Personal and Family History: Please indicate whether you or a family member have had in the past (P) or is currently (C) affected by any of the conditions listed below.

Condition	Self	Mother	Father	Sister	Brother	Maternal Grand-Mother	Maternal Grand-father	Paternal Grand-mother	Paternal Grand-father	Aunt or Uncle
Age, if living										
If deceased, age and cause										
Anemia										
Asthma										
Auto-immune disease (type)										
Cancer (type)										
Depression										
Diabetes (type)										
Drug addiction										
Eczema										
Epilepsy (seizures)										
Headaches/migraines										
Heart disease										
Hepatitis (type)										
High blood pressure										
High cholesterol										
HIV										
Kidney disease										
Liver disease										
Mental illness (type)										
Neurological illness (type)										
Stroke										
Thyroid disease										
Tuberculosis										
Osteoporosis										
Other										

Review of Systems: Please, indicate whether you have had any of the following (P = past, C =current). If your condition is not listed, please, add below.

	Past or current		Past or Current		Past or Current
Constitutional					
Fatigue		Hot flashes		Weight loss _____ lbs	
Fever		Poor appetite		Weight gain _____lbs	
Night sweats		Food cravings		You desired weight _____lbs	
Thirst		Poor sleep		Weak immune system	
Bleed/bruise easily		Peculiar taste/smell		Dizziness	
Water retention		Chemical sensitivities		Other	

Eyes					
	Past or Current		Past or Current		Past or Current
Poor vision		Spots in front of the eyes		Double vision	
Night blindness		Glaucoma		Blind spots	
Eye pain		Date of last eye exam_____		Other	
Ears, Nose and Throat					
	Past or Current		Past or Current		Past or Current
Ringing in the ears		Poor hearing		Earaches	
Sinus problems		Gum bleeding		Teeth grinding	
Nasal congestion		Runny nose		Hoarseness	
Sore throat		Facial pain		Nose bleeds	
Other					
Cardiovascular					
	Past or Current		Past or Current		Past or Current
Chest pain		Low blood pressure		Palpitations	
High blood pressure		Pace maker		Valve problems	
Irregular heart beat		Swelling of hands/feet		Bleeding disorder	
Blood clots		Cold hands/feet		Varicose veins	
Loss of consciousness					
Respiratory					
	Past or Current		Past or Current		Past or Current
Cough		Coughing blood		Difficulty breathing	
Bronchitis		Asthma		Post nasal drip	
Pneumonia		Pain with deep breath		Snoring	
Emphysema		Wheezing		Other	
Gastrointestinal					
	Past or Current		Past or Current		Past or Current
Change in bowel habits		Blood in stools		Colitis	
Constipation		Rectal pain		Ulcer	
Diarrhea		Bloating		Hemorrhoids	
Abdominal pain		Heartburn		Dark black tarry stools	
Nausea		Vomiting		Gall stones	
Last colonoscopy date_____		Other			
Genitourinary					
	Past or Current		Past or Current		Past or Current
Pain on urination		Urgent urination		Incontinence	
Frequent urination		Infections		Decrease flow of urine	
Blood in urine		STD		Cystitis	
Kidney stones		Change in libido		Night urination	
Discharge from urethra					
Males					
	Past or Current		Past or Current		Past or Current
Prostate problems		Impotency		Infertility	
Abnormal sperm analysis		Testicular pain/ lump		Genital sores	
Date of last prostate exam_____		Other			

Females					
	Past or Current		Past or Current		Past or Current
Number of pregnancies		Infertility		Irregular periods	
Number of births		Endometriosis		Heavy menstrual flow	
Number of miscarriages		Age at 1st menstruation		PMS sx What kind_____ _____	
Number of abortions		Time between periods		Vaginal discharge	
Number of premature births		Duration of periods		Vaginal sores	
Difficulty conceiving		First day of last period		Bleeding in between periods	
Birth control type _____		Menopause Age_____		Uterine fibroids	
Currently pregnant		Breast lumps		Painful periods	
Currently breast-feeding		Date of last mammogram_____		Abnormal PAP	
Date of last gyn exam _____		HPV positive		Other	
Musculoskeletal					
	Past or Current		Past or Current		Past or Current
Neck pain		Knee/ankle/foot pain		Metal implants	
Back pain		Hip pain		Tingling	
Arm/hand/wrist pain		Shoulder pain		Numbness	
General muscle pain		Popping/cracking joints		Joint swelling	
Gout		Arthritis		Osteoporosis	
Other					
Skin/hair					
	Past or Current		Past or Current		Past or Current
Dandruff		Dry skin		Acne	
Itching		Open sores		Eczema	
Rashes		Poor healing		Hair loss	
Psoriasis		New moles		Other	
Neurological					
	Past or Current		Past or Current		Past or Current
Headaches Where_____		Loss of balance		Numbness	
Head trauma When _____		Weakness		Tingling	
Memory issues		Speech problems		Tremor	
Seizures		Vertigo		Lack of coordination	
Paralysis		Other			
Psychiatric					
	Past or Current		Past or Current		Past or Current
Depression		Personality changes		Mood changes	
Anxiety		Easily stressed		Poor concentration	
Eating disorder		Other			
Endocrine					
	Past or Current		Past or Current		Past or Current
Excess thirst		Heat/cold intolerance		Hypoglycemia	
Frequent urination		Fatigue after exercise		Excessive hunger	
Difficulty maintaining steady weight		Other			

Hematology/lymphatic/immune					
	Past or Current		Past or Current		Past or Current
Anemia		Easy bruising		Bleeding disorder	
Swollen lymph nodes		Lymphedema		History of anaphylactic reaction	
Immune system problems		Other			

Comments:

_____
_____
_____
_____
_____
_____
_____

Insurance Benefits Verification Form

Date _____

Patients Name _____ Date of Birth _____

Insurance_____ ID#_____ Group # _____

Called_____ Spoke to_____ Effective Date_____

Acupuncture Benefits _____

Deductible _____ Met _____ Coverage_____

Co-pay _____ Max # of visits _____

PCP Referral? _____ Obtained _____Pre-authorization? _____

What is covered? Are there any exclusions or only certain conditions that are covered?

Conditions_____

Naturopathic Benefits _____

What is covered?

Office visits? _____Preventative? _____ Physical Medicine (massage, manual

manipulations, infrared, ultrasound, electro-stimulation) _____

Deductible _____ Met _____ Coverage_____

Co-pay _____ Max # of visits _____

PCP Referral _____Obtained _____Pre-authorization? _____

Call reference # _____

What is…

- Deductible? Amount that you have to pay before insurance will start paying for services
- Copay? Amount that is due at the time of the visit
- Coinsurance? Remainder balance after insurance has paid their part