

New Patient Intake Form

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Male/ Female(circle)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Referred by: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Health concerns in order of importance:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Current Physicians:

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies (medication, food, environmental):

\_\_\_\_\_

Current Medications/Supplements:

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



Provider Fees and Policies

**Regular Office Hours:** Dr. James is available by appointment. Phone calls and email messages are returned Monday through Friday within 24-72 hours.

**Visit Consultations and Fees:** Dr. James accepts limited insurance plans at her office in Bellingham, WA, and is an out-of-network provider in Hawaii. Payment for office visits is due at the time of service. The first office consult, which includes a comprehensive intake, review of medical records, physical exam and/or evaluation of records, imaging, and labs, and initial treatment plan, generally lasts 60-75 minutes and costs \$450. Follow-up visits last 30-45 minutes and cost \$200. We accept cash, checks and Mastercard or Visa. There is a \$25.00 fee for all returned checks.

**Telephone and Video Conferencing Consultations:** Telemedicine consultation appointments are available for those who live more than 100 miles away or are too ill to make it to the clinic. Insurance will not cover this service unless you have specific plans. Fees for a telephone consult are commensurate with in-person fees. Brief (5 minutes or less) phone calls are accepted at no charge.

**Electronic Policy:** Electronic messages are not a substitute for an office visit. If you need clarification of supplement dosage, medication instruction or refill, this can be provided by message or telephone. Changes in symptoms or changes to the treatment protocol must be addressed in person. Messages are preferred through the Patient Portal of your provider's electronic health record.

**Medical Records and Confidentiality:** Your medical records are confidential and require your written authorization before they can be released to other health care providers or other approved recipients.

**Appointment Cancellations:** We understand that circumstances occasionally arise that will change your plans. You may cancel at no charge if you call **at least 24 hours** before your appointment. If you do not cancel or fail to come for your appointment, a fee of \$50.00 will be charged.

I have read and understand these guidelines and agree to the terms therein.

Signature \_\_\_\_\_

Date \_\_\_\_\_



HIPAA Consent for Use and Release of Information

I give permission to Laura James, ND, FABNO, PLLC, to release any information about me, my health, the health services provided to me, or payment for my health services which may be necessary:

For my treatment – to any physician, or other health care providers or facilities which need the information for my continued care, or

For payment purposes – to determine whether I am eligible for insurance coverage and if this treatment is authorized for payment by my insurance. This information may also be used to process an insurance claim, and for billing and collection purposes, or

For my treatment to persons associated with me named below.

Relationship Name
Relationship Name
Relationship Name

By signing this form, I authorize Laura James, ND, FABNO, PLLC, and associated providers to communicate via electronic message, telephone, video conferencing, and in person with me and with other health care providers and associated persons as necessary for my medical care and treatment.\*\*

My signature on this authorization indicates that I am giving permission for the uses and disclosures of my protected health information. I hereby release Laura James, ND, FABNO, PLLC its associated providers, and its employees from any and all liability that may arise from the release of information as I have directed.

My signature confirms that I am informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that I may request in writing that this clinic restricts how my private information is used or disclosed to carry out treatment, payment, or other healthcare operations. I understand that RCWC is not required to agree to my requested restrictions, but if agreeable is then bound to abide by such restrictions.

Patient or Guardian Signature: Date:

\*\*Complete the following only if email correspondence is being authorized: Patient's Email:

I authorize release of my medical care and treatment to the following health care providers: Health Care Provider: Health Care Provider:

Initials



### INFORMED CONSENT FOR TREATMENT

I, \_\_\_\_\_, hereby authorize Laura James, ND, FABNO, to perform or refer for the following specific procedures as necessary to facilitate my diagnosis and treatment:

**Common diagnostic procedures:** e.g., venipuncture, Pap smears, radiography, laboratory, X-ray.

**Minor office procedures:** e.g., dressing a wound, ear cleansing.

**Medicinal use of nutrition:** e.g., therapeutic nutrition, nutritional supplementation, IV nutrients, and intramuscular vitamin injections.

**Botanical medicine:** botanical substances may be prescribed as teas, alcohol-containing tinctures, capsules, tablets, creams, plasters, or suppositories.

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

**Physical Medicine:** e.g., use of massage, cupping, muscle stretching, exercise therapy, naturopathic manipulation to relieve pain and improve function. May also include use of heating pads, micro-current electrical therapy, craniosacral therapy, or low-level laser therapy.

**Hydrotherapy:** e.g., constitutional hydrotherapy treatments with electrostimulation, contrast baths, and hydrocollator packs.

**Pharmaceutical medicine:** e.g., prescription of drugs or over-the-counter medication.

**Lifestyle counseling and hygiene:** e.g., diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.

**Psychological counseling**

**Contraception**

**Acupuncture**

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

**Potential risks:** allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures.

**Potential benefits:** 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:** All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Laura James, ND, FABNO, PLLC, or any of its personnel 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 unless it is required by 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 seven years after the date of my last visit. 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 physician to the best of her ability.

\_\_\_\_\_

\_\_\_\_\_

Signature of Patient/Patient Guardian or Representative      Date

