

*(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) \_\_\_\_\_

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**In case of emergency, notify:** \_\_\_\_\_

• Home Ph: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_    • Cell Ph: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_    • Work Ph: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

• Relationship to Patient (spouse, father, mother, etc) \_\_\_\_\_

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

Primary Care Provider (Dr.'s name): \_\_\_\_\_

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**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**

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

**Patient/Guardian Signature:** \_\_\_\_\_ *Today's Date:* \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Leah McNeill, ND  
Ohana Wellness Center  
2310 130<sup>th</sup> Ave NE | Suite B-103 | Bellevue, WA 98005

## **PAYMENT POLICY / CANCELLATION POLICY**

**Naturopaths are not always covered by all plans of insurance companies.** 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:

Pacific Physicians Lab --- 425-774-3751  
Diagnos-Techs, Inc. --- 800-878-3787  
Genova Diagnostics --- 800-522-4762

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.
2. If there is a deductible to meet first.
3. Is a referral 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 **try** to give courtesy reminder calls for appointments 1 – 2 days in advance. However it is responsibility to be aware of your appointment date & time.

**We require 24-hour cancellation/reschedule notice or a \$50.00 fee will be charged.  
Missed appointments with no notification will be charged full fees for the appointment.**

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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 \$20.00 for returned checks.**

**We charge \$10.00 fee/month for patient balance portion not paid within 30 days.**

**We charge \$50-\$75 for phone consultations** (Insurance companies do NOT reimburse for this service.)

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- I understand that I am responsible for my account balance with Ohana Wellness Center doctors.
- 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):** \_\_\_\_\_

## Acknowledgment of Receipt of Privacy Practices (HIPPA)

Leah McNeill, ND

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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:

<input type="checkbox"/>	May send an email message:	_____
		Email address
<input type="checkbox"/>	May leave a detailed message on voicemail at home:	_____
		Home phone number
<input type="checkbox"/>	May leave a detailed message on voicemail at work:	_____
		Work phone number
<input type="checkbox"/>	May leave a detailed message on cell phone:	_____
		Cellular phone number
<input type="checkbox"/>	May leave a detailed message at different location:	_____
		Phone number & location
<input type="checkbox"/>	May leave a detailed message with spouse/partner:	_____
		Name of spouse/partner                      phone #
<input type="checkbox"/>	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:** \_\_\_\_\_