Kitsap Clinic of Natural Medicine Inc.
Dr. Katherine Barkshire, ND, RN
1007 Scott Avenue, Suite E Bremerton WA 98310
Ph: 360-475-0400 Fax: 360-450-5787 www.KitsapNaturalMedicine.com

Supplement Shop 360-373-0565

KITSAP CLINIC OF NATURAL MEDICINE

PATIENT INFORMATION

First Name:_____ Middle Initial:_____ Last Name:_____

Address:_____

City/State/Zip:_____

Preferred Phone Number:_____ □ Cell □ Home □ Work □ Other

Alternate Phone Number:_____ □ Cell □ Home □ Work □ Other

Gender Preference: _____

E-mail Address: _____

* Would you like an appointment reminder? □ Via Phone/text □ Via Email □ No Reminder

Date of Birth:_____/_____/_____ □ Single □ Married □ Life Partner □ Divorced □ Widowed

Occupation:_____ Name of Company: _____

Emergency Contact:_____ Phone:_____ Relationship:_____

How Did You Hear About Us? *(Reference, Advertisement, Etc.)* _____

Are you hearing impaired? □ Yes □ No If yes, do you need an interpreter or TTY line? □ Yes □ No

Are you visually impaired? □ Yes □ No Do you have any other special needs? _____

x_____ x _____

Signature of Patient Date Signature of Guardian Date

Relationship to patient: _____

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Please List Specific Health Concerns in Order of Importance to You:

Concern # 1: _____

Date Began:____/____/____Have you seen other health care providers for this? ☐ Yes ☐ No

If yes, what medications or treatments were given:_____

What makes it better?_____Worse?_____

Concern # 2: _____

Date Began:____/____/____Have you seen other health care providers for this? ☐ Yes ☐ No

If yes, what medications or treatments were given:_____

What makes it better?_____Worse?_____

Concern # 3: _____

Date Began:____/____/____Have you seen other health care providers for this? ☐ Yes ☐ No

If yes, what medications or treatments were given:_____

What makes it better?_____Worse?_____

Do you have any opinions regarding what may have caused your health conditions? _____

_____

Do you have any specific goals for your health? _____

_____

Do you have a Primary Care Provider? ☐ Yes ☐ No

If Yes: Doctors Name:_____Phone: _____

Doctors City/State/Zip: _____

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Allergies (Medications, Food, Environmental): _____

_____

Please List Past Surgeries and Hospitalizations:

Surgery/Hospitalization: _____ Date: _____

Name/Location of Hospital: _____

Outcome: _____

Surgery/Hospitalization: _____ Date: _____

Name/Location of Hospital: _____

Outcome: _____

Surgery/Hospitalization: _____ Date: _____

Name/Location of Hospital: _____

Outcome: _____

Please List Past Major Injuries:

Injury: _____ Date: _____

Treatment: _____ Outcome: _____

Injury: _____ Date: _____

Treatment: _____ Outcome: _____

Please List Any Medications You Are Taking:

Med: _____ Dosage: _____ Times/Day: _____ Doctor: _____

Med: _____ Dosage: _____ Times/Day: _____ Doctor: _____

Med: _____ Dosage: _____ Times/Day: _____ Doctor: _____

Med: _____ Dosage: _____ Times/Day: _____ Doctor: _____

Med: _____ Dosage: _____ Times/Day: _____ Doctor: _____

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Please List Supplements / Herbs You Are Taking:

Name & Brand:______________________________Dosage:____________Times/Day:____________
Reason for Taking:____

Name & Brand:______________________________Dosage:____________Times/Day:____________
Reason for Taking:____

Name & Brand:______________________________Dosage:____________Times/Day:____________
Reason for Taking:____

Name & Brand:______________________________Dosage:____________Times/Day:____________
Reason for Taking:____

Name & Brand:______________________________Dosage:____________Times/Day:____________
Reason for Taking:____

Please Indicate Any of the Following:

Cigarettes? ☐ Yes ☐ No If Yes, How Long:__________How Often:__________Quit Date:__________
Vaping? ☐ Yes ☐ No What?_______How often?________________How Long?______________
Alcohol? ☐ Yes ☐ No If Yes, Type:_____________How Often:__________Quit Date:__________
Caffeine? ☐ Yes ☐ No If Yes, What Drink:______________________How Often:______________
Sugar? ☐ Yes ☐ No If Yes, How Much:______________________How Often:______________
Exercise? ☐ Yes ☐ No Type:_______________________________How Often:______________
Food Cravings? ☐ Yes ☐ No For What:______________________How Often:______________
Sleep Problems? ☐ Yes ☐ No Type:__________________________How Often:______________
Weight Change? ☐ Yes ☐ No Gain/Loss:______________________When:___________________
Diet Restrictions? ☐ Yes ☐ No Explain:____

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Personal and Family Medical History:

For grandparents, use P for paternal, M for maternal, PGM= paternal grandmother

Check/circle all those that apply:	Yourself	Mother	Father	Grandparents	Brother/ Sister	Spouse	Children	
Alcoholism/addictions								
Allergies								
Alzheimer's								
Anemia								
Arthritis								
Asthma								
Bleeding disorder								
Cancer **(What type**)								
COPD/ Emphysema								
Depression								
Diabetes								
Eczema								
Heart Disease								
Hepatitis								
High Blood Pressure								
High Cholesterol								
HIV/AIDS								
IBS								
Kidney Disease								
Liver Disease								
Mental Illness								
Migraines/Headaches								
Stroke								
Thyroid disorder								
Tuberculosis								
Ulcers								
Other?								

Females: Number of pregnancies?_____ Number of live births? _____

Last PAP: _____ Last Mammogram: _____

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INFORMED CONSENT FOR TREATMENT

I,_____, hereby authorize the naturopathic physicians of Kitsap Clinic of Natural Medicine, INC to perform 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. cleaning, removing sutures, dressing a wound, ear lavage, skin scraping, skin cryotherapy.
- Medicinal use of nutrition: e.g. therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.
- Botanical medicine: e.g. botanical substances may be prescribed as teas, 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.
- Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.
- Physical medicine: e.g. massage, hot and cold therapy, stretching, manipulation, electrical muscle stimulation, and therapeutic ultrasound.
- Psychological Counseling, Contraception, Vaccination

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 or vaccinations, aggravation of pre-existing symptoms, discomfort, pain, infection, burns, nausea, light headedness, inconvenience of lifestyle changes, injury from injections, venipuncture, or procedures. Notify Kitsap Clinic of Natural Medicine if you experience any symptoms which may be secondary to the above procedures.
• Potential benefits: restoration of health and the body's maximal functional capacity without the use of drugs or surgery, 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.

Note: The Kitsap Clinic of Natural Medicine is not an urgent care center and cannot be utilized as such. Our clinic will do our best to schedule acute patient visits when needed, but cannot guarantee an available appointment time. Kitsap Clinic of Natural Medicine is not open on weekends. Please utilize an urgent care center, when appropriate, for acute care needs.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Kitsap Clinic of Natural Health, 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 a minimum of three, but no more than six 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 practitioner to the best of his/her ability.

_____ _____

Signature of Patient Signature of Patient Representative or Guardian

Date:_____ Date:_____

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FINANCIAL POLICY

Thank you for choosing the Kitsap Clinic of Natural Medicine Physicians as your healthcare provider! We feel that it is very important that our patients have a clear understanding of our expectations regarding billing and payments. Please read and sign the following financial policy prior to your treatment. Should you have any questions, feel free to ask.

Payment is due at the time services are rendered.

If you pay for your services by check and that check is returned for non-sufficient funds, there will be an additional $20.00 charge to your account. Also, you will be asked to remit the amount of the check plus the service charge in cash within 10 days. If there remains a balance on your account, after 30 days, we will refer it to a collection agency.

This practice is committed to providing the best treatment for our patients and our charges are based on a value scale developed by the American Medical Association and supported by most insurance companies.

Showing up for your scheduled appointment time is very important. If you are unable to make your appointment, please give our office 24 hours' notice so that we may give another patient that time. Patients that "no show" or do not cancel 24 hours prior to their appointment may be assessed an appointment charge of $75. This charge is your responsibility.

I HAVE READ AND FULLY UNDERSTAND THE KITSAP CLINIC OF NATURAL MEDICINE FINANCIAL POLICY.

_____ _____

Signature of Patient Signature of Patient Representative or Guardian

Date:_____ Date: _____

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CLINIC FEES

1. Office Visit Fees:

- Initial First Office Visit: $312
- Return Office Visit: $202
- Acute, detail focus $125 15-30 min
- Counseling: $185.00 per hour
- Annual Exam: $200.00
- Nutritional Counseling with food panel review $200 per hour

Additional Costs

- Gynecology exam/pap $28 (labs not included)
- Blood Draw or Injections: $20
- Food Panel/Nutrition lab draw and shipping $25
- Medical Consult $35 (Current patients only. Rx updates, HSA Letters, Referral letters, Massage Rx, misc. consults)
- Visceral Manipulation $95

2. Phone Consultation: $95.00 minimum charge per 20-30 minutes. This fee is not charged if the patient is calling for a clarification of on-going therapy or if the doctor has asked the patient to call. Doctors will do telephone consultations for established clients under certain circumstances when an office visit may not be deemed necessary or possible.
3. Cancellation Charge: There is no charge if your appointment is cancelled with a minimum of 24 hours' notice. If the office is not notified, or with less than 24 hours' notice, you will be charged $95.00.
4. Procedure Fees: There are additional fees for various procedures that may be performed in this office such as therapeutic injections, PAP tests, blood draws etc.
5. Payment: Payment is required at the time of service unless you are on the Member monthly payment option. We accept Master Card, Visa, cash and checks. There is a $20.00 insufficient funds fee for returned checks.
6. Insurance: *It is your responsibility to ensure that your insurance policy covers services from our clinic.* This does not include visceral manipulation, nutrition counseling, or blood draw. We will provide a superbill for you to bill your insurance if you like. You are responsible for billing any secondary insurance as well.
7. Lab Work: Laboratory work originating from this office *may* be covered by your insurance company. The laboratory handles all billing and will bill either you or your insurance company.
8. Chart Copies: Requested copies of charts, other than what we provide, will cost 69¢ per page.
9. Late Fee: There will be a $15.00 late fee accessed for all payments that are 30 days overdue.
We are committed in providing economical, quality health care. Thank you for your patronage.

Signature of Patient

Date:_____

Signature of Patient Representative or Guardian

Date: _____

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____

We keep a record of your health care services that we have provided. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.

By my signature below I acknowledge receipt of the Notice of Privacy Policy.

_____ _____
Patient or legal authorized individual signature Date

_____ _____
Printed Name if signed on behalf of the patient Relationship

AUTHORIZATION FOR VERBAL RELEASE OF INFORMATION

In the course of your care at our clinic, another individual (example: spouse, children, etc) may request information regarding your treatment, test results, diagnosis, or other medically pertinent information. Unless, we have your authorization we cannot release or discuss your healthcare with any other individual. You may authorize our office to leave a message or speak with another individual. Please review the options below and check any or all that apply. This release will be in effect until revoked in writing by you.

__Release the information only to me

__I give permission to discuss my healthcare with _____
Name of individual (spouse, child, friend)

__I give permission to leave my healthcare information on my home/cell answering machine

__I give permission to call me at work. Work # _____

_____ _____
Patient Signature Date

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KITSAP CLINIC OF NATURAL MEDICINE

I Hereby Authorize:

❍ Kitsap Clinic of Natural Medicine, INC

1. Facility/Doctor's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____ Fax #: _____

To Release: ❍ *Complete Chart Record (does not include billing information or radiographic images*

❍ Chart Notes: ❍All ❍Specify: _____
❍ Labs/Reports: ❍All ❍Specify: _____
❍ Billing Records: ❍All ❍Specify: _____
❍ X-rays/Radiographic Images(specify): _____
❍ Other: _____

From the Health Records of:

2.Name: _____ Date of Birth: ____/____/_____
Daytime Phone: _____ ext: _____

Are you authorizing release of your own records? ■ Yes ❍No

Release of certain medical information requires a minor's consent. This applies to persons aged 13 to 17 for information pertaining to substance abuse and mental health information, or persons aged 14 to 17 for information pertaining to sexually transmitted diseases, HIV and AIDS. Other laws may apply.

To Be Released to:

■ Kitsap Clinic of Natural Medicine, INC ❍ **Self** (please provide address below if requesting a copy of your own records)

❍ Facility/Doctor: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____ Fax #: _____

For the Purpose of: ❍Adjunctive/Concurrent Care ❍Transfer of Care ❍ Other: _____

I understand that unless revoked this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.

❍ substance abuse ❍ mental health/psychotherapy notes ❍ sexually transmitted diseases and ❍ HIV/AIDS

I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided for by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would no longer be protected.
I understand that I do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of this authorization form at the time of signing. I may call Kitsap Clinic of Natural Medicine to inquire about revoking this authorization.

_____ **3.** _____
Guardian/Personal Representative's Name (PRINT) Patient's Signature

_____ _____
Relationship/Representative's Authority Patient's Name (PRINT)