Tilia
NATURAL HEALTH

206.257.5817 PH
206.257.5819 FAX
105 NE 56th Street
Seattle, Washington 98105
www.tilianaturalhealth.com

NATUROPATHIC MEDICINE FOR THE WHOLE FAMILY

Patient Information

Today's Date: _____

Legal Name: _____ Nickname: _____

Parent/Guardian Name(s) (if patient is a minor): _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female ☐ Trans ☐ Intersex SSN: _____

Relationship Status: ☐ single ☐ married/partnered ☐ divorced ☐ widowed Spouse's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Phone: _____ (Type: C/H/W) 2nd: _____ (Type: C/H/W)

May we leave confidential messages at either number? ☐ Yes ☐ No If so, please put a star next to the number(s)

Email (only used to contact for official purposes): _____

Employer (patient or parent[s]): _____ Position: _____

Emergency Contact: _____ Relation: _____ Phone: _____

How did you hear about us? _____

Billing Information – Patients paying at time of service are not required to fill out billing section but must sign Authorization

Insurance Company: _____ Plan Name: _____

Insurance Address: _____ Phone: _____

ID Number: _____ Group Number: _____

Whose policy is this? ☐ Self ☐ Spouse ☐ Other Name: _____ DOB: _____

Secondary Insurance: _____

Is your visit due to a recent accident? ☐ Yes ☐ No - If yes, please consult reception for the correct forms

Authorization and Agreement of Payment

I hereby authorize direct insurance payment to my physician for services rendered. I understand that I am responsible for knowing and understanding my insurance policy and Naturopathic benefits and that I am responsible for any co-pays, co-insurances, deductibles or services not covered by my insurance.
I also authorize release of any medical records that may be necessary for either medical care or processing of claims.

_____ _____

Patient/Parent/Guardian Signature Date

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Tilia Natural Health Policies and Fees

We plan for your experience at Tilia Natural Health to be an excellent one and wish to fully inform you of our fees and payment policies.

PAYMENT

Initials

- We accept payment by cash, check, or MasterCard / Visa / debit card.
- Checks denied for lack of funds will incur a fee of $35.00.
- All balances must be paid within 30 days of the invoice date. Balances over 30-days past due will be charged to your card on file. If that charge is denied, you will be invoiced at the end of the month.
- A minimum billing fee of $10.00 or 2%, whichever is greater, will be added to any unpaid balance that is over 30 days past invoice.
- Payment plans are available upon request, though balances over $500 will continue to incur interest.

We reserve the right to make changes to our fees and/or policies without advance notice.

INSURANCE

All charges incurred at our office are your responsibility, regardless of insurance coverage. You are responsible for knowing the terms of your insurance coverage.

- Dr. Eastman's practice requires full payment at time of service. If you have out-of-network insurance coverage for naturopathic care and you wish to submit a bill to request reimbursement for services, please ask for a **superbill** at each visit.
- Dr. Wells is an in-network provider for Regence, Premera, First Choice Network, and FedMed. She is happy to see patients as an out-of-network provider. She provides courtesy billing for patients with out-of-network insurance; payment for the first appointment is taken at the time of service.
- **L&I and PIP Accident Claims:** In the event that your PIP coverage does not fully cover service received at Tilia Natural Health, you are responsible for payment. PIP coverage generally does not cover medications. These must be paid for at the time of purchase.
  Tilia Natural Health accepts L&I payments as payment in full for a claim that has been authorized by the Department of Labor and Industries. If payment is denied, you will be responsible for payment of all charges for service received.

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CLINIC POLICIES

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Purchase & Return of Dispensary Items/ Products

All pharmacy items must be paid for at the time of purchase. Credit on account will be given for unopened items in perfect condition if returned within 30 days. No credit will be given for items returned after 30 days.
Refunds cannot be made.
Medical supplies, products packaged in the clinic, refrigerated products, homeopathic remedies (including UNDA), and birth control devices cannot be returned.

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I agree to make payment according to the policies of Tilia Natural Health. I understand that payment is due according to the terms of provider's practice and my insurance coverage. By receiving products and services from Tilia Natural Health, I am agreeing to pay for those products and services regardless of insurance coverage.

Patient Name (Please Print) _____ Patient / Representative / Guardian Signature _____ Date _____

CREDIT CARD INFORMATION

Cardholder Name: _____ Date: _____

Card Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Exp: ____/____ CCV: _____

Billing Address: _____

I authorize Tilia Natural Health, LLC to charge the portion of my bill that is my financial responsibility to this credit or debit card.

Cardholder Signature: _____

This information is stored securely on your chart and will only be used in the event of unpaid balances over 30-days past due, per the terms of our payment policy. Patients with no card on file will be billed monthly; over-due balances will incur a late fee.

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- Dr. Cole is an in-network provider for Regence, Premera, First Choice Network, LifeWise and FedMed. She is happy to see patients as an out-of-network provider, with payment taken at time of service. She provides courtesy billing for patients with out-of-network insurance.
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NATUROPATHIC MEDICINE FOR THE WHOLE FAMILY

PEDIATRIC INTAKE (6 - 12 years)

NAME: _____ **DOB:** _____

Parent/Caregiver's name: _____

Parent/Caregiver's name: _____

The patient lives with: ☐ mother ☐ father ☐ two parents ☐ other: _____

Siblings (names and ages): _____

_____

Has any other family member already been a patient at this clinic? _____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has as full an understanding as possible of the patient's physical, mental, and emotional state. Your time, thoughtfulness and honesty in completing this overview will greatly aid me in assisting with your child's health care needs.

Why did you choose to come to this clinic; what do you know about our approach?

What *three* expectations do you have from *this* visit to our clinic?

1.
2.
3.

What *long-term* expectations do you have from working with our clinic?

What expectations do you have of me personally as your child's health care provider?

What is your present level of commitment to addressing any underlying issues that relate to your lifestyle choices?

Rate from 0 to 10 - 10 being 100% committed

0% 1 2 3 4 5 6 7 8 9 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your child's health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe may be detrimental to your child's health?

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What potential obstacles do you foresee in addressing any lifestyle factors undermining your child's health?

Who in your child's life will sincerely and consistently support the beneficial lifestyle changes they will be making?

What kind of support do you expect from me as your child's caregiver?

HEALTHCARE STATUS

Name of hospital/clinic(s) where your child's health records are kept: _____

_____

Reason for referral or presenting problems: _____

What your child's most important health problems? List them in order of importance.

Please place a star (*) by any health issues you prefer I NOT discuss in front of your child. This may require separate visits - one for evaluation and one to discuss treatment options.

- _____
- _____
- _____
- _____
- _____
- _____
- _____

Does your child have any contagious diseases at this time? ☐ No ☐ Yes: _____

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NATUROPATHIC MEDICINE FOR THE WHOLE FAMILY

PRENATAL HISTORY

Previous pregnancies for biological mother? ☐ No ☐ Yes: How many? _____

Miscarriages? ☐ No ☐ Yes: How many? _____

Complications? ☐ No ☐ Yes: _____

Mother's age at child's birth: _____

Mother's health during pregnancy *(check all that apply)*:

☐ Bleeding ☐ Nausea ☐ Illnesses unrelated to pregnancy

☐ Hypertension ☐ Thyroid problems ☐ Diabetes – gestational or preexisting

☐ Tabacco, alcohol, or drug use ☐ Medications unrelated to pregnancy

☐ Physical or emotional trauma ☐ Other: _____

BIRTH HISTORY

The child was born: ☐ Term ☐ Premature: _____ ☐ Post-term/late: _____ Length of labor: _____

Complications: ☐ No ☐ Yes: _____

Birth location (city & state/country): _____ Time: _____ Weight: _____

Did your child experience any of the following problems shortly after birth?

☐ Rashes ☐ Jaundice ☐ Colic ☐ Birth Defects

☐ Seizures ☐ Cerebral Palsy ☐ Fever ☐ Birth injuries

☐ Other: _____

Child's sleep patterns 1st year: _____

Breast fed: ☐ No ☐ Yes - How long: _____ Formula: ☐ No ☐ Yes – Type: _____

Age started solid foods: _____ What foods: _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

HEALTH HISTORY

Previous Illnesses

Please mark any diseases you had as a child:

☐ Rheumatic Fever ☐ Chicken Pox ☐ Tonsillitis – Number of times: _____

☐ German Measles ☐ Measles ☐ Ear Infections – Number: _____

☐ Other(s): _____

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Hospitalizations, Surgery and Imaging

Has your child had any hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs or other procedures?

Procedure:_____Year:_____ Procedure:_____Year:_____

Procedure:_____Year:_____ Procedure:_____Year:_____

Procedure:_____Year:_____ Procedure:_____Year:_____

Evaluations

Has your child ever had any of the following tests? If so, list when and where.

Psychological evaluation: _____

Hearing tests: _____

Speech / Language tests: _____

Immunizations – *check those that your child has received, in full or in part*

☐ Polio ☐ Tetanus ☐ Measles/Mumps/Rubella

☐ Pertussis ☐ Diptheria ☐ Influenza

Any adverse reactions? ☐ No ☐ Yes – What was the reaction and with which immunization did it occur?

_____

_____

Allergies

Known allergies or sensitivities – *please list all known allergens/irritants*

Drugs: ☐ No ☐ Yes: _____

Foods: ☐ No ☐ Yes: _____

Enviromnentals/chemicals: ☐ No ☐ Yes: _____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

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Current Medications

Please list any other prescription medications, over the counter medications, vitamins or other supplements your child is taking, *including the dosage*:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (*please check and write who*)

☐ Cancer	☐ Diabetes	☐ Heart Disease	☐ High Blood Pressure
☐ Kidney disease	☐ Epilepsy	☐ Arthritis	☐ Glaucoma
☐ Tuberculosis	☐ Stroke	☐ Anemia	☐ Mental Illness
☐ Asthma	☐ Hay fever	☐ Hives	☐ Depression or Suicide
☐ Eating Disorder	☐ Genetic Disorder	☐ Dementia	☐ Alcoholism / Addiction
☐ Learning Disabilities	☐ Osteoporosis	☐ Migraines	☐ Obesity
☐ Parkinson's	☐ Multiple Sclerosis	☐ Alzheimer's	☐ Other: _____

Other relevant family history? _____

What is your family heritage? _____

REVIEW OF SYSTEMS

For the following, please circle:

Y - yes/condition you have now **N** - no/never had **P** - problem in the past

MENTAL/EMOTIONAL

Mood Swings	Y	N	P
Irritability	Y	N	P
Hyperactivity	Y	N	P
Introvert / Extrovert	Y	N	P
Motion / car sickness	Y	N	P
Anxiety / Nervousness	Y	N	P
Cries Easily	Y	N	P
Unusual fears	Y	N	P
Sleep problems	Y	N	P
Nightmares	Y	N	P
Have a history of abuse?	Y	N	P
Experienced a major trauma?	Y	N	P

ENDOCRINE

Heat or cold intolerance?	Y	N	P
Fatigue?	Y	N	P
Excessive thirst?	Y	N	P
Excessive hunger?	Y	N	P
Low blood sugar?	Y	N	P
High blood sugar?	Y	N	P

SKIN

Rashes?	Y	N	P
Eczema or hives?	Y	N	P
Psoriasis?	Y	N	P
Acne/boils?	Y	N	P
Itching?	Y	N	P

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HEAD
- Headaches? Y N P
- Head injury? Y N P
- Dizzy spells? Y N P
- High fevers? Y N P

EYES
- Impaired vision? Y N P
- Tearing or dryness? Y N P
- Eye pain or strain? Y N P

EARS
- Ear aches? Y N P
- Impaired hearing? Y N P

NOSE AND SINUS
- Frequent colds? Y N P
- Nose bleeds? Y N P
- Stuffiness? Y N P
- Hayfever? Y N P
- Sinus problems? Y N P
- Loss of smell? Y N P

MOUTH AND THROAT
- Frequent sore throat? Y N P
- Canker sores? Y N P
- Breath odor? Y N P
- Dental cavities? Y N P

RESPIRATORY
- Cough? Y N P
- Wheezing? Y N P
- Asthma? Y N P
- Bronchitis? Y N P

CARDIOVASCULAR
- Heart disease? Y N P
- Murmurs? Y N P

URINARY
- Increased frequency of urination? Y N P
- Bedwetting? Y N P

GASTROINTESTINAL
- Belching or passing gas? Y N P
- Stomach aches? Y N P
- Constipation? Y N P
- Diarrhea? Y N P
- Bowel movements: how often? _____

MUSCULOSKELETAL
- Joint pain or stiffness? Y N P
- Muscle spasms or cramps? Y N P
- Broken bones? Y N P

CARDIOVASCULAR
- Anemia? Y N P
- Easy bleeding or bruising? Y N P
- Heart palpitations? Y N P

NEUROLOGIC
- Seizures? Y N P

****FEMALE REPRODUCTIVE**
- Has menstruation begun? Y N
- Any symptoms? _____
- Has breast development begun? Y N

****MALE REPRODUCTIVE**
- Have both testes descended? Y N

Is there any information about your child's health that you would like to add?

Welcome! We are honored to be of service for you and your child!