Catalyst Natural Health

201 N Edison St. Suite 236
Kennewick, WA 99336

Phone: 509-579-0150
Fax: 509-737-1319

Patient Registration Forms

Today's Date: _____

First Name of Patient	Middle Name of Patient	Last Name of Patient
Date of Birth	Street Address	
City	State	Zip
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner		
Occupation	Preferred Pharmacy (Name and Address)	
Home Phone	Cell Phone	Email
* Confidential voicemails OK? YES NO (circle which number we can leave confidential messages)		

Emergency Contact		
Name	Phone	Relationship

Name of Primary Care Provider and Clinic	
Name of other providers/specialists involved in your care	
Date of last physical	Date of last bloodwork

How did you hear about us?	

Circle how ready are you to work on your health:	1 = Not ready to change. 10 = Ready, willing & able! 1 2 3 4 5 6 7 8 9 10

List your top 4 health concerns, in order of importance to you, the most important listed first:

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Last Name: _____ First Name: _____ Date of Birth: _____

Medications and supplements
(including prescription, over-the-counter, vitamins, minerals, herbs, and homeopathics)

Medication/supplement & brand (valtrex, CoQ10 costco)	Strength and Dosage (e.g. 10 mg once daily, 1 tbsp with lunch, etc.)	Reason for taking it (e.g. Diabetes, etc.)

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Medical History

(Check the box to indicate you or a family member has the following condition. Please specify relatives)

Health Condition	Self	Relative	Health Condition	Self	Relative
Alzheimer's Disease			Heart Murmur		
Anemia			HIV/AIDS		
Anxiety			Hypertension		
Arthritis			Infertility		
Asthma			IBS/Crohn's Disease		
Blood Transfusion			Kidney Disease		
Cancer			Meningitis		
Cataracts			Osteoporosis		
Congestive Heart Failure			Parkinson's Disease		
Clotting Disorder			Seizures		
COPD			Sexually Transmitted Disease		
Cysts			(please specify)		
Depression			Sickle Cell Anemia		
Diabetes			Stroke		
Elevated lipids (chol, tri, LDL)			Substance Abuse		
Emphysema			Thyroid Disease		
GERD			Tuburculosis		
Glaucoma			Ulcers		
Heart Attack			Other (specify)		

Surgical History & Hospitalizations

Type of surgery/reason for hospitalization	Date (month and year)

Allergies and reaction (anaphylaxis, itchy eyes, etc.)

Allergy	Reaction (mild-severe; please describe)

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Social History

Do you use any of the following substances regularly?

	Amount/Usage
Coffee	
Tea	
Soda pop	
Alcohol	
Recreational Drugs (please specify)	

Tobacco (current or past)
_____ packs per day
_____ years smoking
Quit Date: _____

Currently Pregnant: YES NO (if yes, number of weeks: _____)

Number of Pregnancies: _____ Children: _____ Currently Breastfeeding: YES NO

Last Menstrual Period:_____/_____/_____

Dietary Information

Are there any foods you avoid?

Exercise Information

Do you exercise regularly? If so what do you do and how often?

I certify that all the information I have provided on pages 1-4 of the registration forms is true and accurate to the best of my knowledge.

Name of Patient/Legal Guardian (Print Name)

Patient/Legal Guardian Signature

Date

Financial Aggreement

Payment is due at time of service. We accept cash, credit cards, and personal checks from established patients. There will be a returned check fee of $30. In this event, payment is due within 15 days. If payment is not received within 15 days, an additional 1.5 % monthly penalty will be added to the balance. Two returned checks within one year will result in the loss of being able to pay via check.

Insurance, Medicare and Medicaid

We do not bill insurance. However, you may request a superbill with CPT and diagnostic codes that you can submit directly to your insurance company for possible reimbursement. It is your responsibility to determine if your insurance company covers our services. If this is important to you, we advise you to contact your health insurance company for details about coverage for services provided by naturopathic physicians before your visit. Dispensary items may not be covered by insurance. However, you may be able to submit to a health savings account. Your treatment plan may serve as a prescription for this if needed. Unfortunately, none of the services we offer are reimbursable by Medicare, including secondary policies, or Medicaid. If you have Medicare or Medicaid, all services and expenses will be an out of pocket cost.

Cancelation and No Show Agreement

When you make an appointment, we reserve that time just for you. We often prepare ahead of time, thus we require a 24 hour notice if you are unable to make your appointment. When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. On your second no-show occurence, there will be a $60 dollar charge to your account. After three consecuritve no-show occurences, the practice may elect to terminate our relationship with you. Exceptions may be made for medical emergencies, severe or inclement weather, or other situations deemed acceptable by the physician. Forgetting to obtain requested lab/bloodwork before your appointment is not an acceptable exception for canceling or rescheduling your appointment. You will receive a reminder email 7 days prior to your scheduled appointment in order to get results for lab/bloodwork done ahead of time.

Telephone and online digital evaluation and management policy

We recognize our treatment plan may not always be clear once you get home, therefore brief straightforward questions over the phone or online, concerning your treatment plan within 7 days, are answered at no cost. For all other detailed questions, if more than 5 minutes is needed to access your chart and study aspects of your case beyond 7 days of the initial visit, or if the inquiry involves discussion of new symptoms and/or treatment options, you will be prorated in 10 minute increments at $120/hr. If your inquiry requires further research, or if the doctor needs more information from you in order to asnwer your question, we request you schedule an appointment.

Notice of Privacy Practices

Catalyst Natural Health is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have received it. If you have questions concerning the management of your healthcare information at our clinic, please call us at (509) 579-0150.

Acknowledgement: Financial Agreement, Cancelation/No Show Agreement, Telephone and Online Digital Evaluation and Management Policy, and Notice of Privacy Practices

I have read and fully understand the financial agreement, cancelation and no show agreement, telephone and online digital evaluation and management policy, as stated above. I understand that Catalyst Natural Health will not bill my insurance for any expenses, and that I am fully responsible for all charges. I have read and fully understand the Notice of Privacy Practices as stated above.

_____

Name of Patient/Legal Guardian (Print Name)

_____ _____

Patient/Legal Guardian Signature Date

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Consent for Treatment

Consent for Treatment

Your Naturopathic treatment at Catalyst Natural Health may include any or all of the following general modalities: nutrition and lifestyle counseling, herbal medicine, physical medicine, and homeopathy. We may perform general diagnostic procedures, give dietary advice, apply topical treatments, perform hydrotherapy, and give exercise recommendations. We may also use herbal medicine and supplementations, perform osseous manipulations and soft tissue massage, and use electromagnetic therapies.

I have read and fully understand the above statements. All questions regarding my treatment have been answered to my complete satisfaction. I understand that a record will be kept of the health services provided to me.

Name of Patient/Legal Guardian (Print Name)	Relationship to Patient
Patient/Legal Guardian Signature	Date

***For patients seeking supportive cancer care**

By signing consent for treatment, I understand that Washington State law does not authorize Naturopaths to treat me for any cancer or malignancy and that I am required to be under the care of a medical doctor or osteopathic physician (oncologist) while receiving care at Catalyst Natural Health.

I am currently under the care of _____ and understand that I am solely seeking adjunctive/supportive therapies at Catalyst Natural Health.

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Permission to treat a Minor Without Parent/Guardian (If Applicable)

Consent To Treat a Minor

This form gives Catalyst Natural Health legal permission to treat your child in case you cannot accompany him/her to the clinic for treatments. Consent may include, but is not limited to clinic visits, medical treatment, and tests. A parent/legal guardian must accompany the minor to their first visit.

Patient (Minor's) First Name	Patient (Minor's) Middle Name	Patient (Minor's) Last Name

A. I hereby authorize (caregivers name, i.e. grandparent, babysitter):

_____

to give consent to any medical or surgical treatment by any licensed physician in the State of Washington for our child at Catalyst Natural Health.

B. Please *initial here { }* if you are authorizing the minor to attend appointments (and consent to treatment) with **no** adult present.

Emergency contact

Primary Contact's Name	Relationship	Phone
Secondary Contact's Name	Relationship	Phone

I acknowledge that I am responsible for all charges associated with the treatment and care of the above stated minor patient.

_____ _____

Name of Patient/Legal Guardian (Print Name) Relationship to Patient

_____ _____

Patient/Legal Guardian Signature Date