Red Cedar Wellness Center

Amy Bosworth-Patton, ND • Laura A. James, ND • Janile Martin, ND • Donna Kachinskas, ND

1601 116th Avenue NE • Suite 100 • Bellevue, WA 98004 • Phone: 425-451-0999

INFORMED CONSENT FOR TREATMENT

I, ________________________________, hereby authorize the physicians at Red Cedar Wellness Center 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, and intramuscular vitamin injections.
Botanical medicine: botanical substances may be prescribed as teas, alcoholic 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.
Hydrotherapy: e.g., constitutional hydrotherapy treatments with electrostimulation, contrast baths.
Manual Therapy: e.g., musculoskeletal physical therapy, massage, craniosacral techniques
Acupuncture: e.g., the stimulation of energy points along body meridians to promote health
Pharmaceutical medicine: e.g., prescription of pharmaceutical drugs as determined by Washington State naturopathic scope of practice.
Lifestyle counseling and hygiene: e.g., diet therapy, biofeedback training, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.
Psychological counseling
Contraception

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: If I am pregnant or suspect pregnancy, I will alert the doctor, as some of the therapies used could present a risk to the pregnancy.

Notice to cancer patients: I am aware that in the State of Washington I must have a medical oncologist to provide oncology treatment. I authorize the physicians of Red Cedar Wellness Center to review my records and discuss my health and treatment with other care providers. I authorize the release of medical information necessary to file a claim with my insurance company.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Red Cedar Wellness Center 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 ten 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.

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 RCWC restricts how my private information is used or disclosed to carry out treatment, payment, or health care operations. I understand that RCWC is not required to agree to my requested restrictions, but if agreeable then is bound to abide by such restrictions.

______________________________ ______________________________
Signature of Patient or Guardian Date

NEW PATIENT INTAKE FORM

Name____ **Date**__________________________

Date of Birth____________________ **Age**_______________ **Male/ Female**(circle)

Address____

City_______________________ **State** ________ **Zip**_____________ **SS#** _______________________________

Phone__________________**Cell** ______________________ **Email** __________________________________

Occupation________________________________ **Leave Message at** _________________________________

Referred by ____

Emergency Contact ____

Insurance Information

Subscriber Name and ID Number ____

Subscriber Date of Birth______________________ **Plan/Group ID Number** ______________________________

Subscriber SS# ____________________________ **Relationship to Patient** ___________________________

Subscriber Phone Number ____________________ **Subscriber Employer** _______________________________

Health concerns in order of importance:

1.________________________2.________________________3.__________________________________

Current Physicians:

Name:____ Specialty:___________ Phone:_______________

Name:____ Specialty:___________ Phone:_______________

Name:____ Specialty:___________ Phone:_______________

Health History

___Cancer (type:__________________) ___Surgery (type:________________)

___Alcoholism	___Allergies	___Anemia	___Asthma
___Arthritis	___Colitis	___Diabetes	___Gout
___Heart Disorder	___Herpes/Shingles	___High Blood Pressure	___Indigestion
___Traumatic Injury	___Liver disorder	___Lung Disorder	___Menstrual Problems
___Psychological	___Pregnancies (# __)	___Skin Disorder	___ Stroke
___Thyroid	___Tuberculosis	___Other (______________________)	

Allergies (medication, food, environmental): ____

Current Medications/Supplements:

____

____

Other Comments:

____

Signature____________________________________ Date___________________________________

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, ___________________________________, give permission to ____
(Patient's/Guardian's name) (Clinic, institution, health professional)
To disclose health information in the medical records of:

____DOB: ______________SS#: __________________________
(**PRINT** name of patient)

Information to be sent to: **Red Cedar Wellness Center**
1601 -116th Ave NE, Ste. 100 Bellevue, WA 98004-3034
Phone Number: (425)-451-0999 **Fax number** (425)-451-7399

Information to be released:

- ☐ Progress Notes
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ EKG's
- ☐ Problem List
- ☐ Medication List
- ☐ Immunizations
- ☐ Consultations
- ☐ Accounting of Disclosure
- ☐ Other (please specify) ____

Specify date(s) of treatment requested: ____

Purpose for which disclosure is being made: (Please check one of the following)

☐ Attorney ☐ Insurance ☐ Doctor ☐ Personal

My Rights:
I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study, or
- To receive health care when the purpose is to create health information for a third party

I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to our patients. I understand that once ***[client's name]*** discloses health information, the person or organization that receives it may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE: ____ DATE: ____________________
(Patient, Guardian*, or Authorized Representative*).
[*Please provide documents to prove authority to sign on behalf of the patient.]

This authorization will expire 365 days from the date signed. Possible copying fee required.

If you desire a copy of this authorization, please notify a representative of the Medical Records department upon completion of this form.

RED CEDAR WELLNESS CENTER

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www.redcedarwellness.com
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Provider Fees and Services

Amy Bosworth-Patton, ND, PLLC
Laura A. James, ND, PLLC
Dr. Janile Martin, Inc.
Donna Kachinskas, PhD, ND, PLLC

Regular Office Hours: Monday 10:00am to 5:00pm, and 9:00am to 5:00pm Tuesday through Friday. Doctors are available by appointment. Only Dr. Kachinskas is a primary care provider.

Visit Consultations and Fees: The first office consult, which includes a comprehensive intake, review of medical records, physical exam, and initial treatment plan, generally lasts 60 minutes and ranges from $200-$350. Follow-up visits last 30-60 minutes and range from $100-$200. Acupuncture services and biofeedback training are provided in conjunction with a physician follow-up visit. Manual Therapy visits are billed at $23 per 15-minute increment, and must be paid in full at the time of service. Labwork and nutritional supplements are not included in these fees. Payment is due on day of service. We accept cash, checks, Mastercard, Visa, and Discover. There is a $25.00 fee for all returned checks

Telephone Consultation: After an initial visit, telephone consultation appointments are available for those who live out of town or prefer telephone consultation. Insurance will not cover this service. Fees for a telephone consult are $50.00 for each 15 minutes. Brief phone calls are accepted at no charge. Messages are checked daily and will be returned within 48 hrs.

Insurance Billing: Our doctors are credentialed by most major insurances. It is the patient's responsibility to check if our doctors are covered by your specific insurance plan. If Dr. Martin is not listed or covered for Naturopathic services, insurance billing may be possible under her additional Nurse Practitioner status. Claims denied by your insurance plan will be billed to you directly.

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

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 hrs** 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_____________________________________