EVERGREEN
NATUROPATHIC

Where patient education is first and foremost…

Patient Information Packet

Record of Disclosures, Patient Consent Form, Financial Consent Form

We are located in the Rock Pointe Corporate Center in the Rock Pointe Tower.

“2-hour visitor parking” is located in front of the building.

Please be advised that Google Maps may direct you to the wrong location.

Parking entrance on N Washington Street

Parking entrance on N Normandie Street

Our Practitioners

Dr. Alycia Policani

Dr. Policani is a Licensed Naturopathic Physician. She received her Bachelor of Science in Human Biology from Eastern Washington University in 1996 and her Doctorate of Naturopathic Medicine from National College of Naturopathic Medicine in Portland, OR in 2000.

Dr. Tanya Paynter

Dr. Paynter is a Licensed Naturopathic Physician. She received her Bachelor of Science in Cellular and Molecular Biology with a minor in Inorganic Chemistry in 2000. She received her Doctorate of Naturopathic Medicine from Bastyr University in Washington in 2012.

Dr. Michael Lehman

Dr. Lehman is a Licensed Naturopathic Physician. He earned his Bachelor of Science in Health Psychology and Human Biology from Bastyr University (WA) in 2014 and his Doctorate of Naturopathic Medicine from Bastyr University (CA) in 2018.

Naturopathic medicine is about respecting the body's intelligence. Every symptom you experience is your body's way of telling you that you are doing something to cause an imbalance. If you continue to ignore your body's messages you will spiral farther down the slope into chronic disease. By choosing to follow the appropriate diet and lifestyle plan for your body, decreasing stress, and nutritionally supporting your weak areas, you can achieve optimal wellness.

We believe that the beginning of healing starts with the basics - healthy food, proper breathing, sound sleep, and a balance between work and play. We feel that many of today's health problems can be stopped, and even reversed, with simple changes to the way we live. We enjoy helping support and guide our patients in those changes, leading them to wellness. We use multiple methods, including testing, dietary recommendations, biofeedback and counseling, nutraceuticals, physical medicine, lifestyle changes, herbs, and pharmaceuticals.

Services

- Acute care, colds/flus, infections
- Sprains/strains, injury care
- Management of chronic disease
- Hormone and Thyroid care
- General Wellness Exams
- Family Medicine
- Pre-Op Exams
- Biopuncture
- Nutrient Injections
- Naturopathic Soft Tissue Technique
- Phone Consults
- Women's Annual Exams
- Men's Annual Exams
- Menopause & Hormone Balancing
- Men's Health
- Sports Physicals
- Telemedicine
- NatureCare Membership Plans
- IV Therapy
- Venipuncture (Blood Draws)
- Multiple Specialty Lab Tests

Notice of NON-Covered Services

The following treatments, services, or laboratory testing are not or may not be covered by your insurance plan, your health savings plan, or reimbursed by any third party payer on your behalf.

- Biopuncture
- Phone Consults
- Telemedicine
- US BioTek Food Allergy Test
- Biofeedback
- Nutrient Injections
- Genova Tests
- Biotechnologies Elisa ACT Test
- Doctor's Data Testing
- Naturopathic Soft Tissue Techniques
- DUTCH Precision Analytical Hormone Test
- Therapeutic Nutrient Injections
- IV Therapies
- Aerodiagnostics Lactose Breath Test
- Venipuncture (Blood Draws)
- Diagnostic Solutions GI Test
- Boston Heart Test

The reasons these services may not be covered could be, but not limited to the following:

1. The service is excluded from your benefit plan coverage.
2. The service had not been authorized by my health plan.
3. This service may be determined to be a preventative, or wellness procedure not covered by third party payers.

I hereby acknowledge that I understand the above services are not or may not be covered by the benefits available to me under the terms of my health plan, insurance policy, or any third party payer.

I understand that I am financially responsible to pay for these services at the time of my visit or as instructed by Evergreen Naturopathic.

I understand that Nutrient Injections, IV Therapy and Venipuncture services will be required to pay prior to service.

I understand that there are no refunds for any testing, treatment, or service.

Patient Printed Name: ________________________ Date: ____________________

Minor Printed Name: ________________________ Date: ____________________

Patient/Guardian Signature: ____

Consent for Treatment

I hereby request and consent to examination and treatment with Naturopathic care, including various modes of physical therapy for: ___ Myself, or, ____, for whom I am responsible.

I understand that there will be times during which I seek immediate treatment that my normal physician is not available and consent to be seen by any provider at Evergreen Naturopathic.

I understand that this consent to care includes treatment received by nursing staff, medical assistant - phlebotomist staff at the direction of the providers.

I understand that naturopathic evaluation includes commonly used physical examination methods and movements to test bones, joints, nerves, muscles, and other tissues and organs to help determine the diagnosis and course of treatment.

I understand that I am in full control of my body during the examination and it is my responsibility to inform the health care providers of any procedure I feel may cause injury or want stopped for any reason.

I understand that, as a patient, I have a right to be informed about my condition and recommended care. This disclosure is to help me become better informed so I may make the decision to give or withhold my consent as to whether or not I want to undergo care after having had the opportunity to discuss potential benefits, risks, and hazards involved.

I understand that naturopathic evaluation and treatment may include, but is not limited to, various modes of physical therapy (ultrasound, diathermy, low volt electrical stimulation, hydrotherapy, heat, cold, traction, stretching, exercise, etc.) collecting specimens for laboratory evaluation including blood draws, cultures, and/or dietary therapy, biofeedback, and homeopathy.

I understand that naturopathic modalities continually change and that Evergreen Naturopathic seeks to keep pace with new and effective modalities and may add or stop providing certain services at any time.

I understand that, at this time, the Food and Drug Administration has not yet approved nutritional, herbal, and homeopathic supplements but that they have been widely used in the US and Europe for many years.

I understand that, as with drugs, nutritional supplements, herbal remedies, and homeopathic remedies may exhibit some side effects in certain sensitive individuals, interact with certain allopathic medications or lab tests, or exacerbate symptoms in certain pre-existing disease conditions.

I do not expect the providers to be able to anticipate and explain all risks and complications. I wish to rely on the doctor(s) to exercise judgment and ability to anticipate and explain all risks and possible complications. I wish to rely on the providers to exercise judgement in recommending treatment that the provider feels at the time, based on the facts then known, are in my best interest.

I acknowledge that I have the opportunity to ask questions and discuss, to my satisfaction, with the provider the following;

1. My suspected diagnosis or condition.
2. The nature, purpose, and potential benefit of the proposed care.
3. The inherent risks, complications, potential hazards, or side effects of the treatment or procedure.
4. The probability or likelihood of success.
5. Reasonable available alternatives to proposed treatment/procedures.
6. The possible consequences if treatment advice is not followed and/or if nothing is done.

I understand and am informed that in the practice of naturopathic medicine there are some risks of examination and treatment. I further acknowledge that no guarantees or assurances have been made to me concerning the results of treatment. I further acknowledge that no guarantees or assurances have been made to me concerning the results of treatment. By signing below, I acknowledge that I have read, or have had read to me, and understand the above consent. I consent to care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment or care from Evergreen Naturopathic and its employees.

Print Patient Name: ______________________________ **Date of Birth:** ______________________________

Minor Printed Name: ______________________________ **Date of Birth:** ______________________________

Patient or Legal Guardian Signature: __________________________ **Date:** ______________________________

Notice of Privacy Practices

I acknowledge that I have received and read a copy of Evergreen Naturopathic's Notice of Privacy Practices.
Notice of Privacy Practices is also available within Evergreen Naturopathic's lobby and website

Financial Consent / Billing Practices

I understand that in compliance with HIPAA, no billing information, including but not limited to balances, dates of services, and insurance information, will be released to a third party for patients over the age of **13** without a current third party release form on file.

Time of Service Discount: I understand that per insurance regulations our self pay/time of service discount price adjustment of 20% can only be offered at the time of service. This CANNOT be applied to a third party payer denial of a claim for any reason. If you choose to take advantage of the Time of Service Discount you are prohibited from billing your insurance as this would be an illegal act and considered insurance fraud.

I understand that if I am uncertain if my insurance or any third party will cover a service that I am responsible for the full amount of the services received.

I understand that quoted benefits from my insurance company or third party payer is not a guarantee of payment and I agree that I am financially responsible for all charges accrued for services rendered.

I agree that should I receive a statement with a balance due, I will pay the balance in full, or make payments arrangements within 30 days of the statement received.

I agree that if I carry a balance for 60 days or more without payment arrangements, I will not be eligible for any treatments or services until the balance is paid in full.

Phone Consultation Agreement: I understand that Phone Consultations are available on a self pay basis only. I understand that payment at the time of service is required for telephone consultations.

Establishing Care: I understand that my initial consultation will ONLY be for establishing care and does not include an Annual Examination within that 60 minute time frame. Depending on your insurance provider this may not be a 100% covered service.

Missed Appointments: I understand that if I do not show up or an appointment, or do not cancel with at least 72 (New Patient) 48 (Established Patient) business hours notice, that I will be charged the full amount of the visit. I acknowledge that these fees range from $152.00 to $294.00.

Formulary: I understand that there are **no refunds** for any items purchased from our in-house formulary.

Patient Name: ______________________________ **Date of Birth:** ____________________

Minor Name: ______________________________ **Date of Birth:** ____________________

Patient or Legal Guardian Signature: ______________________ **Date:** ____________________

New Patient Intake Form

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Dfcj]XYf. 5`mW]U Dc`]WUb]žB 8 fl Ł   HUbmU DUmbhYfžB 8 fl Ł   A]WXUY`@Y\a UbžB 8 fl Łs s

DUma Ybh HmdY. ±bgi fUbWY fl Ł GY`Z DUm fl Łs 6YmcbX D]b_ fl Łs s

s

Name: ______________________ Date: ______________________

Social Security #: ______________________ Date of Birth: ______________________

Age: ________ Sex: __________ Height: ______________________ Weight: ______________________

Mailing Address: ____

City, State, Zip: ____

Phone Number: ______________________ May we leave detailed messages? (i.e. appointment reminders) ___Y ___N

Occupation: ______________________ Full / Part Time: ______________________

Email: ______________________ We will never share your email with any third party.

May we send you email or text to confirm your appointment? ____ Y ____N Cell Carrier: ______________________
Would you like to receive our monthly newsletter? ____ Y ____N

Marital Status: ___Single ___Married ___Co-Habitating ___Divorced ___Separated ___Widowed

With Whom do you live?: ___Alone ___Spouse ___Friends ___Relatives ___Parents ___Other

Spouse Name: ______________________ How many Children do you have? ______________________

Emergency Contact: ______________________ Phone: ______________________

Primary Health Provider: ______________________ Phone: ______________________

How did you hear about Evergreen Naturopathic?
___ Personal Referral: Please provide their name so we may thank them: ______________________

___ Business Referral: Please provide their name so we may thank them: ______________________

___ Website ___Facebook ___Insurance: ______________________

___ Print Ad: Which one? ______________________

Patient Questionnaire

Name: ____**Date:**____________________________**DOB:**_______________

Scheduled With: ___Dr. Alycia Policani ___Dr. Tanya Paynter ___Dr. Michael Lehman

Scheduled For: Initial New Patient Visit ____ Beyond Pink Follow Up ____

Present Health Concern/Reason for Appointment Today:____

Medication List: Please list any medications (including dose). *If there is not enough room, please provide a detailed Medication list.*

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D\Ufa UWmDfYZYfYbWY.ss fIB Ua Yž @cWUh]cbŁS			

Supplement List: Please list any supplements (including dose). *If there is not enough room, please provide a detailed Supplement list.*

Gi dd`Ya YbhBUa Ys	8cgY fÎY/) a [ž%\$a [žYhW\žS	F YUgcb Zcf hU_]b[s	<ck `cb[3s

Patient Questionnaire Continued

Allergies: *Please list any known allergies and reactions to them. If you do not have any, circle "none".*

Drugs/Medications: *None* Food: *None* Environmental: *None*

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

Lifestyle

Current Tobacco use: (Circle One) *None* *Daily* *Weekly* *Monthly* Amount? ____________________

Previous history of smoking? (Circle One) *Yes* *No* How long? _____________ Quit Date? _______________

Recreational Drug use? (Circle One) *None* *Daily* *Weekly* *Monthly* Type/Amount? __________________

Exercise: *None* *Type?*____ *Frequency?* __________________

Diet

Diet: (Please list any guidelines or avoidances. (ie Gluten Free, Vegetarian, Avoids Sugar, etc.)

____

Estimate Daily Amounts of the Following: Water Intake: ____________ Coffee/Black Tea: ____________

Soft Drinks: ____________ Alcohol: ____________________

Sleep/Energy: (Circle any of the following that you struggle with.)

Falling Asleep *Staying Asleep* *Waking Frequently* *Waking refreshed*

Rate your energy level on a scale of 0 - 10. (10 being the best) ___________________________________

Medical History

Major Events and Year: (Any hospitalizations, accidents, broken bones, surgeries, serious illnesses)

M'Ufs	A U^cf <YU'h\ 9j Ybh 8YgW]dh]cbs

List Ongoing Problems / Current Diagnosis:

____

Patient Questionnaire Continued

Have you taken any antibiotics in the past year? Yes No

If yes, list type, dose, and for what purpose:____

How many times have you taken antibiotics in the past 10 years?_____________________________________

Date of latest complete blood work: _________________________ Do you have these results with you today? ____________

Family History: Please check each box below for every condition that applies.

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7 UbWYfS		: UhYfS		A chYfS		6fchYfS		G]ghYfS		; fUbXZUhYfS		; fUbXa chYfS		9l hYbXYX : Ua]mS
7\Ya]WU 8YdYbXYbWmS		: UhYfS		A chYfS		6fchYfS		G]ghYfS		; fUbXZUhYfS		; fUbXa chYfS		9l hYbXYX : Ua]mS
8]UVYhYgS		: UhYfS		A chYfS		6fchYfS		G]ghYfS		; fUbXZUhYfS		; fUbXa chYfS		9l hYbXYX : Ua]mS
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A YbhU =`bYggS		: UhYfS		A chYfS		6fchYfS		G]ghYfS		; fUbXZUhYfS		; fUbXa chYfS		9l hYbXYX : Ua]mS
Ghfc_YS		: UhYfS		A chYfS		6fchYfS		G]ghYfS		; fUbXZUhYfS		; fUbXa chYfS		9l hYbXYX : Ua]mS
ChYf.S		: UhYfS		A chYfS		6fchYfS		G]ghYfS		; fUbXZUhYfS		; fUbXa chYfS		9l hYbXYX : Ua]mS

Review of Systems: **N = Never C = Currently Experiencing P = Past**

For the following, please circle whether you have had the listed conditions; never, currently, or in the past. "N" means you have never had the condition, "C" means you currently have the condition, and "P" means you have had the condition in the past. Please be complete - every condition listed below helps point us to the underlying source of your health concerns.

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B][\h Gk YUhg #<ch : `Ug\YgS			
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9M9GS			
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95FGS			
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8Ybh U DfcV Ya gS			
8Ybh U DU]bS			

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8÷ 9GH=CBS			
5VXca]bU DU]bS			
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BUi gYU cf Jca]h]b[S			
7cbgh]dUh]cbS			
@ccgY Ghcc g#8]Uff\YUS			
<YUfhVi fb#5W]X FYZi I S			
<cUfgYbYgg#@cgg cZJ c]WYS			
7\Ub[Y]b 5ddYh]hYS			
6 ccX]b Ghcc gS			
@]j Yf#; U V UXXYf 8]gYUgYS			
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AIG7I @CG? 9@9H5@S			
>c]bh DU]b cf Gh]ZZbYggS			
6fc_Yb 6cbYgS			
AigWY GdUga g#7fUa dgS			
8UhY cZ@Ugh 89L53S			

B9IFC@C; =7S			
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GY]ni fYgS			
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AigWY K YU_bYggS			
Bi a VbYgg cf H]b[ ]b[S			
@cgg cZA Ya cfm#6fU]b ZC[S			
7cbWi gg]cb #<YUX =b^i fmS			
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A9BH5@#9ACH=CB5@S			
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8YYd`@Y[`DU]bS			
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HYbX`hc`fib`\ch`cf`Wc`XS			
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GYbg]h]j]hm`hc``][\hS			
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9lWYgg]jY`K`cffmS			
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8]ZZ]Wi`hm`7cbWYbhfUh]b[S			
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B][\h`GkYUhgS			
5WbYS			

5bl]Yhm`cf`BYfjcigbYggS			
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:fYeiYbh`6`UXXYf`=bZYWh]cbgS			
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:9A5@9`GD97=:=7S			
6`YYX]b[`VYhkYYb`DYf]cXgS			
9IWYgg]jY`:`ck#7`chh]b[S			
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I certify that the above information is correct to the best of my knowledge. I will not hold Evergreen Naturopathic responsible for any errors or omissions that I may have made in the completion of this form.

I acknowledge that I am financially responsible for all charges that may apply during the course of my care at Evergreen Naturopathic.

I acknowledge that if Evergreen Naturopathic is contracted with my insurance carrier, and if I have Naturopathic benefits available to me, Evergreen Naturopathic will only bill my insurance as a courtesy.

I acknowledge that a charge will be assessed equal to the cost of the scheduled appointment for all appointments missed without 72 (New Patient) 48 (Established Patient) hours notification.

I acknowledge that if I am more than 20 minutes late to my appointment it will be counted as a missed appointment and I will be charged the missed appointment fee.

Insurance Carrier: ____ Patient ID # ___________________________

Description of Naturopathic Benefit: ____

Preferred Lab: ____

Patient Name: ____ Date of Birth: _________________________

Minor Name: ____ Date of Birth: _________________________

Patient or Legal Guardian Signature: ____ Date: _____________________