

To those with Health Insurance

My job, as I see it, is to get your body working the best it can.
I try to give you good value for the money you spend.

Health Insurance does a poor job of covering alternative medicine.

Health insurance DOES NOT pay for supplements, many of the treatments or therapies done in office, nutritional products, or compounded pharmacy prescriptions. Often times I will recommend lab testing that is done with labs that are not contracted with insurance companies. These labs will bill most insurance companies but you should expect them not to be covered by your insurance company. If you have Aetna – these labs will not bill your insurance company. Group Health does not cover many of these labs and no treatments-just office visits.

Before you begin naturopathic care in Dr. Rivers's office, please be ready to spend your own money on your care and treatment. If you do not have a budget for out of pocket expenses, you may want to wait to start naturopathic care or stay with mainstream medicine. I will bill your insurance whenever possible and appropriate.

Obviously, before the initial visit I do not know what I will recommend for your care, so I cannot give you a precise amount. As a guideline, I would expect that roughly \$200 would be a reasonable amount for the start of treatment, spread out over different days or treatments.

I hope this helps you better understand what you can expect in terms of insurance benefits and out of pocket expense for naturopathic medicine.

Dr. Kaiten Rivers, ND

INSURANCE REGISTRATION

Patient name: _____
Last First Middle

Mailing address: _____ City _____ St _____ Zip _____

Home address if different: _____

Home phone: _____ Age: _____ Date of Birth: _____

Marital status: S M W D SS#: _____

Name of parent if patient is a minor: _____

Employer: _____ Work #: _____

Employer address: _____ City: _____ Zip: _____

INSURANCE INFORMATION

(Please provide card for copying)

Primary Insurance

Secondary Insurance

Name: _____

Name: _____

Subscriber: _____

Subscriber: _____

I.D. #: _____

I.D. #: _____

Group #: _____

Group #: _____

Employer/Plan: _____

Employer/Plan: _____

Auto Accident: _____
Yes No

Work Injury: _____
Yes No

Claim #: _____

Claim#: _____

Date of Injury: _____

Date of injury: _____

Referred by? _____

FOR THOSE WITH INSURANCE COVERAGE:

You are responsible for knowing all the terms and conditions of your insurance policy, auto claim, or work injury claim. This includes but is not limited to limitations of coverage (in terms of dollar amounts, conditions, and services that are covered and excluded, i.e. wellness exams and preventative medicine visits), necessity of referrals, and coverage for lab and diagnostic studies.

Dr. Rivers will provide you with the CPT codes, if applicable, if requested, so you may verify coverage with your insurance company.

We understand this can be confusing and frustrating to investigate, but as policies vary greatly this is the best way for you to understand your benefits.

You agree to pay for all services, lab, etc, if not covered by your insurance.

Signature _____ Date _____

Printed Name _____ Date _____

***Please fill out to the best of your knowledge:**

Deductible: _____

Copay: _____

Number of Visits allowed: _____

Dr. Kaiten Rivers, ND

Naturopathic Physician
1302 North I Street
Tacoma, WA 98403
(253) 572-0939

Office Policies

TREATMENT PLANS

Dr. Rivers' main goal is for you to be as healthy as you want to be and are willing to put the effort, time and resources toward. Treatment plans are designed to be comprehensive in nature. They often involve multiple types of treatment, testing, etc. Dr. Rivers realizes she is prescribing for personalities, life styles and budgets as well as health goals and conditions. Some people like to move fast, some slow. Some like to do several things at once and some one at a time; and everyone has a budget to consider. Your input is requested in designing your treatment plan for maximum success. We want you to be comfortable and confident with your commitment to health.

SUPPLEMENT REFILLS

We have a relatively small dispensary. We recommend that you call ahead before coming by to pick up your supplements to make sure we have them on hand for you. This also allows us to have everything set aside for you when you get here.

POLICIES

- Items are paid for at time of service: supplements, fees for services rendered, co-pays, or percentage for those with insurance coverage.
- After hour pages: Dr. Rivers is available for urgent needs via pager 24 hours a day. If you use this service between 6PM and 9AM Monday-Friday, anytime Saturday, Sunday, or holidays there will be a \$25.00 fee charged to your account. This fee generally cannot be billed to insurance companies.
- Cancellations and No-Shows: If you cannot keep your scheduled appointment, please notify us so we can reschedule your appointment. Appointments cancelled with less than 24-hour notice and no-shows are subject to a \$35.00 missed appointment fee. This charge cannot be billed to insurance companies.
- Collection Services: Any account that has not been satisfied in 60 days will be turned over to a collection agency.
- Returned Check Fees: There will be a \$25.00 charge per check for checks returned for insufficient funds. You are expected to make good on the charges or make payment arrangements within five (5) days of notification. Unpaid balances may be turned over to collection agencies.
- Methods of Payments: Cash, Check, VISA and Master Card
- Phone Consultation Charges: Return phone calls from the Doctor that are longer than five minutes will be subject to a telephone consultation fee. There is no charge for short phone calls clarifying questions regarding your treatment plan.

I have read, understood and agree to the policies listed above.

Signature

Date

Printed Name

Kaiten Rivers N.D.
1302 North I Street
Tacoma, WA. 98403
(253) 572-0939
Patient Profile

Date _____

Name _____ Age _____ Birthdate _____ Sex _____

Address _____ City _____ State _____ Zip _____

Phone (home) _____ (work) _____ Marital Status: S M W D

Cell phone _____ e-mail _____

May we contact you at any of the above numbers/addresses? Y/N Which are excluded? _____

Social Security # _____

Employer (name & address) _____
Occupation _____

Name in case of Emergency _____ Phone _____

What other health care are you presently receiving? _____

Where did you hear about our clinic? _____

Payment Information: Payment is due when services are rendered. Will you be making payment today? Y/N Will we be billing your insurance company? Y/N If so, have you verified your benefits? Y/N Please present insurance card and ID for photocopying.

A Note To Our Patients: Naturopathic, holistic & preventive health care are only possible when the physician has a complete picture of the patient physically, mentally & emotionally. Please complete this questionnaire as thoroughly as possible. Thank you.

Present Health Concerns: In your opinion, what are your most important health concerns in their order of significance? Please indicate the problem that motivated you to come in today.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Are you interested in preventive care (as opposed to condition treatment)? Y/N

Your Health History:

Health as a child? _____ Good _____ Fair _____ Poor _____
Childhood illnesses: _____ Scarlet Fever _____ German Measles _____ Measles _____ Mumps _____

Hospitalizations (year & reason) _____

Surgeries (year & type) _____

Serious illnesses or injury (year & cause) _____

Vaccinations (year, type adverse reaction?) _____

Medications: prescription & non-prescription drugs, herbs, vitamins -- please include everything (pills, tablets, liquids, ointments, suppositories, etc) and indicate dosage.

| | |
|---------|---------|
| 1 _____ | 2 _____ |
| 3 _____ | 4 _____ |
| 5 _____ | 6 _____ |
| 7 _____ | 8 _____ |

Allergies: List any allergies you have to:

Drugs _____

Foods _____

Other _____

What happens when you have an allergy attack: _____

Habits:

Substance use: Alcohol Y N Tobacco Y N Caffeine Y N Recreational Drugs Y N Soda Y N

Diet: Any diet restrictions or regimen? Describe: _____

Are you satisfied with your diet as it is now? __Y__N

Do you crave starches? __Y__N Sweets? __Y__N Salt? __Y__N Fats? __Y__N

Do you eat three meals daily? __Y__N

Do you: Sleep well? __Y__N Wake rested? __Y__N Average hrs of sleep _____

Exercise __Y__N What type? _____

How long? _____ How often? _____

Family History:

Check those applicable Father Mother Brothers Sisters Spouse Child

Age (if living) _____ _____ _____ _____ _____ _____

Age (at death) _____ _____ _____ _____ _____ _____

Cause of death _____ _____ _____ _____ _____ _____

Health G-good P-poor _____ _____ _____ _____ _____ _____

Cancer _____ _____ _____ _____ _____ _____

Diabetes _____ _____ _____ _____ _____ _____

Heart Disease _____ _____ _____ _____ _____ _____

High Blood Pressure _____ _____ _____ _____ _____ _____

Stroke _____ _____ _____ _____ _____ _____

Epilepsy _____ _____ _____ _____ _____ _____

Mental Illness _____ _____ _____ _____ _____ _____

Asthma, hay fever, hives _____ _____ _____ _____ _____ _____

Anemia _____ _____ _____ _____ _____ _____

Kidney Disease _____ _____ _____ _____ _____ _____

Glaucoma _____ _____ _____ _____ _____ _____

Tuberculosis _____ _____ _____ _____ _____ _____

Syphilis _____ _____ _____ _____ _____ _____

Alcoholism/addiction _____ _____ _____ _____ _____ _____

Thyroid Disease _____ _____ _____ _____ _____ _____

Autoimmune Disease _____ _____ _____ _____ _____ _____

Other _____

Your blood type A O AB B **Rh+ Rh-** _____

Your normal body temperature _____

Known toxic exposures: _____

Are you 'chemically sensitive'?(do you react adversely to medicines, solvents, fragrances, etc?) Y N

Review of systems: Y- a condition you have now, N=never had, P- a condition you have had in the past.

GENERAL

Weight _____
 Weight 1-year ago _____
 Maximum weight _____
 When _____
 Height _____
 Night sweats Y P N
 Fatigue Y P N
 Date of last physical _____

SKIN

Rashes Y P N
 Inflammation Y P N
 Infection Y P N
 Growths Y P N
 Chng in hair/nail Y P N

HEAD

Headaches Y P N
 Head injury Y P N

EYES

Impaired vision Y P N
 Eye pain Y P N
 Tearing or dry Y P N
 Double vision Y P N

EARS

Impaired hearing Y P N
 Ringing Y P N
 Earache/itch Y P N
 Dizziness Y P N

NOSE & SINUS

Frequent colds Y P N
 Nose bleeds Y P N
 Stuffiness Y P N
 Sinus problems Y P N
 Post nasal drip Y P N

MOUTH & THROAT

Freq sore throat Y P N
 Sore tongue Y P N
 Sores mouth/lip Y P N
 Gum problem Y P N
 Hoarseness Y P N
 Dental problems Y P N

BLOOD

Anemia Y P N
 Easy bleeding or bruising Y P N

RESPIRATORY

Cough Y P N
 Spitting up blood Y P N
 Wheezing Y P N
 Difficulty breathing Y P N
 Pain on breathing Y P N
 Shortness of breath Y P N
 " lying down Y P N
 " at night Y P N
 Positive TB test Y P N

HEART

Heart disease Y P N
 High blood pressure Y P N
 Rheumatic fever Y P N
 Chest pain Y P N
 Swelling in ankles Y P N
 Palpitations, fluttering Y P N

DIGESTION

Trouble swallowing Y P N
 Heartburn Y P N
 Stomach pain Y P N
 Change in thirst Y P N
 Change in appetite Y P N
 Nausea Y P N
 Vomiting Y P N
 Bowels move daily more less
 Loose stools Y P N
 Is this a change Y P N
 Blood in stools Y P N
 Belching or gas Y P N
 Liver/gallbladder disease Y P N
 Hemorrhoids Y P N

URINARY

Pain on urination Y P N
 Increase frequency Y P N
 Frequency at night Y P N
 Inability to hold urine Y P N
 Bladder infections Y P N

NECK

Swollen glands Y P N
 Pain/stiffness Y P N

Review of systems: Y=a condition you have now. N=never had. P=a condition you have had in the past.
Please circle the following:

CIRCULATION

- Deep leg pain Y P N
- Cold hands/feet Y P N
- Varicose veins Y P N

NEUROLOGIC

- Fainting Y P N
- Seizures Y P N
- Paralysis Y P N
- Muscle weakness Y P N
- Numbness Y P N
- Loss of memory Y P N

ENDOCRINE

- Thyroid problem Y P N
- Heat/cold intolerance Y P N
- Hypoglycemia Y P N
- Excessive thirst Y P N
- Excessive hunger Y P N
- Easy weight gain Y P N

Female Reproduction

- Age menses began _____
- # of days menstrual flow _____
- Length of cycle _____
- Bleeding betw. periods Y P N
- Are cycles regular Y P N
- Pain during intercourse Y P N
- Cramps Y P N
- Abnormal vag. discharge Y P N
- Excessive flow Y P N
- PMS Y P N
- Date of last Pap smear _____
- Abnormal results Y P N
- Date of last period _____
- # of pregnancies _____
- # of live births _____
- # of miscarriages _____
- Birth control _____
- What type? _____
- Difficulty conceiving Y P N
- Menopausal symptoms Y P N
- Are you sexually active? Y P N
- Sexual difficulties Y P N
- Venereal disease Y P N

(Following question is optional)

Sexual Preference:

Heterosexual _____ Bisexual _____ Lesbian _____

No. of Abortions _____

BREASTS

- Regular self-exams? Y P N
- Lumps Y P N
- Pain or tenderness Y P N
- Nipple discharge Y P N

EMOTIONAL

- Depression Y P N
- Mood Swings Y P N
- Anxiety/nervousness Y P N
- Tension Y P N

MUSCULOSKELETAL

- Joint pain/stiffness Y P N
- Broken bones Y P N
- Muscle spasms/cramps Y P N
- Weakness Y P N

Male Reproduction

- Hernias Y P N
- Testicular masses Y P N
- Testicular pain Y P N
- Are you sexually active Y P N
- Sexual difficulties Y P N
- Prostate problems Y P N
- Venereal disease Y P N
- Discharge or sores Y P N
- Difficulty starting or stopping urination Y P N
- Birth control Y P N
- What type? _____

Indicate on Diagram any problem areas:

