

Port Orchard Natural Medicine

Dr. Rachel Robertson
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Port Orchard, WA 98366
(360) 876-5000

Patient Information

Date: _____

Name: (Person filling out the information) _____

Date of Birth: _____ Age: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Emails will be sent out ONLY to notify you about up coming presentation.

Is there a phone number where I can leave confidential information pertaining to your health?

Please circle: Home Work Cell

Name of Spouse/partner living with you: _____

Please circle: Married Single Divorced Widow Separated Partner

Children:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

If appointment is for a child, please complete.

Child's name: _____

Address if different: _____

City: _____ State: _____ Zip: _____

Referring provider: _____

Person to contact in case of emergency.

Name: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Primary Insurance:

Is this visit injury related? _____ Work Injury? _____ Auto Injury? _____

Insurance company name: _____

Phone: _____

Claims address: _____

City: _____ State: _____ Zip: _____

Subscriber's name: _____

Date of Birth: _____ Relationship to patient: _____

ID/Claim # as shown on insurance card: _____

Group # _____

Employer of insured: _____

Effective/injury date: _____

Secondary insurance:

Insurance company name: _____

Phone: _____

Claims address:

City: _____ State: _____ Zip: _____

Subscriber's name: _____

Date of Birth: _____ Relationship to patient: _____

ID/Claim # as shown on insurance card: _____

Group # _____

Employer of insured: _____

Effective/injury date: _____

Authorization For Treatment

The undersigned hereby authorizes the doctor to perform diagnostic tests deemed necessary for my care, to perform any and all forms of treatment, medication and therapy that are indicated and that I am in agreement with and are in accordance with the standards of naturopathic care.

I understand that I am ultimately responsible for any expenses incurred at Port Orchard Natural Medicine. I agree to pay for any missed appointments that are not cancelled or rescheduled with at least 24 hours notice.

Dr. Robertson may recommend specialty labs that are not covered by insurance companies. These specialty labs, which are processed by Genova or Metamatrix are considered by insurance companies to be investigational/experimental. If you chose to do these tests they must be paid in advance to receive the prepaid discount.

Patient signature: _____

Patient name (printed): _____

Date: _____

Parent or responsible party: _____

Relationship to party: _____

Hippa Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, a notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to our privacy practice, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Office Phone Number.

Your signature below acknowledges that you have received a copy of Port Orchard Natural Medicine's brochure "Notice of Privacy Practices":

Patient's Name: _____

Patient's Signature: _____ Date: _____

Parent signature of minor (under 18 years age): _____