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

The information you provide here helps the provider understand your health more completely in order to help you attain your wellness goals. Please answer all questions as completely as possible.

Provider: Alycia Policani, ND ( ) Tanya Paynter, ND ( ) Michael Lehman, ND ( )

Payment Type: Insurance ( ) Self-Pay ( ) Beyond Pink ( )

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.*

Medication Name	**Dose** (ie; 5mg, 10mg, etc.)	**Reason for taking**	**How long?**
Pharmacy Preference: (Name, Location)			

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

Supplement Name	**Dose** (ie; 5mg, 10mg, etc.)	**Reason for taking**	**How long?**

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)

Year	Major Health Event Description

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.

Autoimmune Dz		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family
Cancer		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family
Chemical Dependency		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family
Diabetes		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family
Heart Disease/Attack		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family
High Blood Pressure		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family
Kidney Disease		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family
Mental Illness		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family
Stroke		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family
Other:		Father		Mother		Brother		Sister		Grandfather		Grandmother		Extended Family

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.

Symptom	N	C	P	Symptom	N	C	P
GENERAL				LUNGS			
Fever/Chills				Persistent Cough			
Night Sweats / Hot Flashes				Spitting up Blood			
Memory Loss / Brain Fog				Wheezing			
Insomnia				Difficulty Breathing			
HEAD/NOSE/THROAT				Shortness of Breath			

Headache/Migraines			
Sinus Problems/Congestion			
Recurrent Sinus Infections			
Seasonal Allergies			
Difficulty Swallowing			
Frequent Sore Throat			
Nose Bleeds			
Frequent Runny Nose			
EYES			
Dryness			
Eye Pain			
Blurring			
Eye Discharge			
EARS			
Impaired Hearing			
Ringing (tinnitus)			
Recurrent Ear Infections			
MOUTH			
Gum Problems/Bleeding			
Hoarseness			
Dental Problems			
Dental Pain			
HEART			
Heart Disease			
High Blood Pressure			
Chest Pain			
Swelling in Ankles			
Palpitations, Fluttering			

DIGESTION			
Abdominal Pain			
Gas or Bloating			
Nausea or Vomiting			
Constipation			
Loose Stools/Diarrhea			
Heartburn/Acid Reflux			
Hoarseness/Loss of Voice			
Change in Appetite			
Blood in Stools			
Liver/Gallbladder Disease			
Hemorrhoids			
MUSCULOSKELETAL			
Joint Pain or Stiffness			
Broken Bones			
Muscle Spasms/Cramps			
Date of Last DEXA?			
NEUROLOGIC			
Fainting			
Seizures			
Paralysis			
Muscle Weakness			
Numbness or Tingling			
Loss of Memory/Brain fog			
Concussion / Head Injury			
Dizziness			
MENTAL / EMOTIONAL			
Depression			

Deep Leg Pain			
Cold Hands/Feet			
Varicose Veins			
Anemia			
Easy Bleeding/Bruising			
SKIN			
Acne			
Eczema			
Hives			
Rashes			
Infection			
ENDOCRINE			
Tend to run hot or cold			
Fatigue/Very Low Energy			
Goiter/Enlarged Thyroid			
Cold Hands/Feet			
Sensitivity to light			
High Stress			
Sugar Cravings			
Excessive Worry			
Fluid Retention/Bloating			
Mood Swings			
Easily cry/tearful			
Difficulty Concentrating			
Incontinence			
Hot Flashes			
Night Sweats			
Acne			

Anxiety or Nervousness			
Eating Disorder			
Suicidal Thoughts			
Suicide Attempts			
GENITOURINARY			
Pain on Urination			
Increased Frequency			
Urgency			
Increased Urination at night			
Frequent Bladder Infections			
STD			
Discharge or Sores			
FEMALE SPECIFIC			
Bleeding between Periods			
Excessive Flow/Clotting			
Cramps			
PMS			
Breast Tenderness before Menses			
IUD/Birth Control			
Abnormal PAP? Date of Last Exam: _____			
Supplemental Estrogen/Progesterone If “C” how long? _____			
Hysterectomy (Circle) Y N — Full or Partial			
Date of Last Menstrual Period: _____			
MALE SPECIFIC			
Hernias			
Testicular Masses			
Testicular Pain			
Difficulty Stopping or Starting Urination			

Hair Loss				Prostate Issues			
Weight Gain around hips/waist				Difficulty initiating/maintaining erection			
Decreased Libido				Morning erections present			
Decreased Muscle Mass				OTHER:			
Increased Joint Pain							
Bone Loss							

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: _____

Patient Authorization for Use and Disclosure of Protected Health Information

By signing,_____ I Authorize Evergreen Naturopathic to disclose certain protected health information (PHI) about me to the following person(s):

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Narne:_____ Relationship:_____

Information to be released (initial all that apply):

____Diagnosed Conditions ____Labs, Imaging, and Other Test Ordered and./or Results
____Information Discussed During Office Visits Referrals
____Treatnent Plans
____Supplements
____Billing Information/Balance Due
____Other_____

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

Patient Authorization:

I understand that my record may contain information regarding the diagnosis or treatment or HIV (AIDS virus), other sexually transmitted diseases (STDs), sexual history, drugs and/or alcohol use/abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

****Exclude the following information from the records released (please initial)****

_____Drug/Alcohol use/abuse treaünent and diagnosis **_____Sexual history/STDs**

_____HIV/AIDS diagnosis/treatment/testing **_____Mental Illness diagnosis/treatment**

I do not have to sign this authorization in order to receive treatment from Evergreen Naturopathic. I have the right to make changes to or revoke this authorization in writing at any time. To review the process for revoking this authorization, please read the Privacy Notice posted at the facility where your information is being released.

Patient Printed Name:: _____Date:_____

Minor Printed Name: _____Date:_____

Patient Signature: :_____ Date Of Birth:_____