Sweet Pea Family Medicine
Dr. Kristina Olson-Kuyper ND

Pediatric Health History Questionnaire

Name_______________________________________ **Date** ________________

Holistic health care and preventive medicine are only possible when the physician has a complete understanding of your physical, mental, emotional and spiritual nature. Therefore, please take the time to carefully and thoroughly complete your questionnaire. Print all information and mark anything you don't understand with a question mark.

Pediatric Intake Form (0-12 years)

Date of Birth:____ Age: ___________________

Gender: ________________Race: ________________ Birth Weight: ________________________

Where did your child last receive health care? ___________________ When? ______________

Reason for last visit: ____

Please list your health concerns in order of importance:

1. ____
2. ____
3. ____
4. ____

What has already been done for the above mentioned problems (not applicable for well child visit)?

____

____

____

____

Does your child have a contagious disease at this time? Y N

If yes, what? ____

____

Birth History

List major patterns of illness present in the child's birth mother, father or their families: __________

____

____

____

____

____

Did mother receive prenatal care? Y N Prenatal vitamins? Y N

Did mother take any medications during the pregnancy (type)? ____________________________

____

Did mother smoke cigarettes? Y N Drink alcohol? Y N

Take any illicit drugs? Y N If yes, what type? ______________________________

____

Any difficulties with the pregnancy (nausea, vomiting, bleeding, etc.): ______________________________

____

____

____

Type of birth (eg. Hospital, home, C-section) ______________________________

____

Pregnancy carried to term: Y N If no, how premature: ______________________________

____

Complications of labor or delivery: ______________________________

____

____

____

Breast fed? Y N How long? __________ Formula? Y N If yes, what type? ______________

____

At what age was solid food introduced? ______________________________

____

Previous Illnesses

Describe difficulties during infancy (eg. Colic, skin or lung problems): ______________________________

____

____

____

____

____

Has your child ever had a major illness causing you to seek medical attention?

____

____

____

____

Please list traumatic events in your child's life that you believe have impacted their health:

____

____

____

____

Allergies (Please list any drugs, foods, or substances and your reaction):

How often does your child get (never, occas, freq, const):

Colds Sore Throat Earaches Coughs Diarrhea

Constipation Tummy aches Other

Exposure Are you aware or do you suspect that you have been exposed to toxic substances in your home or work environment? Please describe

Please list (or submit a copy of your list) of all prescription medications, over the counter medications, vitamins or other supplements you are currently taking:

Has your child has any of the following? When? Where? What were the results?

Electroencephalogram? Y N

Psychological evaluation? Y N

Hearing Tests? Y N

Speech/Language tests? Y N

Childhood illnesses:

Rheumatic fever	Y	N	Measles- 2 week	Y	N	German measles-3 day	Y	N
Chicken pox	Y	N	Eczema	Y	N	Asthma	Y	N
Ear infections?	Y	N	Do you have your tonsils?	Y	N	Mononucleosis	Y	N

Other ____________________

Immunization History

X = Up to date **P** = partial **0** = not done

Preschool:

HBV (hepatitis B) __________ Hib (homophiles influenza type B) _________ HAV (hepatitis A) ___________

DTap (diphtheria, tetanus, pertusis) ___________ IPV (polio) ____________ Varicella (chicken pox) _______

MMR (measles, mumps, rubella) ______________ PCV (pneumococcal bacteria)

School Age:

Tdap (tetanus, diphtheria, pertussis) __________ MCV4 (meningitis) ____________Influenza ____________

HPV _______________ Other (eg. Travel vaccines): ____

Reactions to immunizations? Y N If yes, please explain: ____

___

FAMILY HISTORY:

Check those applicable	Father	Mother	Brother	Sister	Spouse	Child
Age (if living)						
Health: G=good P=poor						
Cancer (type?)						
Diabetes						
Heart attack or heart failure						
High blood pressure						
High cholesterol						
Stroke						
Epilepsy						
Mental illness						
Asthma, hay fever, hives						
Anemia						
Kidney disease						
Glaucoma						
Osteoporosis						
Tuberculosis						
Rheumatoid arthritis						
Thyroid disease						
Age deceased						
Cause of death						

Hospitalizations and Surgeries (list reason &/or type of surgery and date):

____

____

Last blood work (type & date) ______________________________

Last physical ____________________ Last EKG ____________________

Last dental exam/cleaning ____________________ Last eye exam ____________________

Last chest x-ray ____________________

Please circle: Y= ***a condition/circumstance you have now*** **N=** ***never had condition*** **P=** ***Past condition/circumstance***

General:

Weight ______________			
Weight 1 yr ago _______			
Satisfied with weight?	Y	N	
Height ______________			
Fatigue	Y	N	P
Night sweats	Y	N	P

Skin:

Rashes	Y	N	P
Eczema, hives	Y	N	P
Acne, boils	Y	N	P
Itching	Y	N	P
Color change	Y	N	P
Lumps	Y	N	P
Herpes	Y	N	P

Head:

Tension headaches	Y	N	P
Migraines	Y	N	P
Hair loss	Y	N	P
Head injury	Y	N	P

Eyes:

Change in vision	Y	N	P
Double vision	Y	N	P
Glaucoma	Y	N	P
Cataracts	Y	N	P
Eye pain	Y	N	P
Tearing or dryness	Y	N	P
Glasses or contacts	Y	N	P

Ears:

Hard of hearing	Y	N	P
Ringing	Y	N	P
Dizziness	Y	N	P
Earache	Y	N	P

Nose/sinuses:

Frequent colds	Y	N	P
Stuffiness	Y	N	P
Sinus infections	Y	N	P
Hay fever	Y	N	P
Frequent nose bleeds	Y	N	P

Mouth & throat:

Frequent sore throat	Y	N	P
Sore/swollen tongue	Y	N	P
Difficulty swallowing	Y	N	P
Hoarseness	Y	N	P
Frequently clear throat	Y	N	P
Bleeding/receding gums	Y	N	P
Dental cavities	Y	N	P
Toothache/sensitivities	Y	N	P

Neck:

Lumps	Y	N	P
Swollen glands	Y	N	P
Goiter	Y	N	P
Pain or stiffness	Y	N	P

Respiratory:

Asthma	Y	N	P
Emphysema	Y	N	P
Frequent cough	Y	N	P
Productive cough	Y	N	P
Bronchitis	Y	N	P
Shortness of breathe	Y	N	P
Wheezing at night	Y	N	P
Wheezing lying down	Y	N	P
Wheezing on exertion	Y	N	P
Pain on breathing	Y	N	P
Pneumonia	Y	N	P
Pleurisy	Y	N	P
Tuberculosis	Y	N	P

Cardiovascular:

Heart failure	Y	N	P
Heart attack	Y	N	P
Chest pain/angina	Y	N	P
High blood pressure	Y	N	P
High cholesterol	Y	N	P
Fluttering in chest	Y	N	P
Heart murmur	Y	N	P

Rheumatic fever	Y	N	P
Swelling in ankles	Y	N	P

Gastrointestinal:

Frequent indigestion	Y	N	P
Vomiting	Y	N	P
Vomiting blood	Y	N	P
Blood in stool	Y	N	P
Abdominal pain	Y	N	P
Gallbladder pain	Y	N	P
Liver disease/hepatitis	Y	N	P
Frequent belching/gas	Y	N	P
Heartburn	Y	N	P
Ulcers	Y	N	P
Hemorrhoids	Y	N	P
Constipation	Y	N	P
Diarrhea	Y	N	P

Bowel movements How often? ___________

Is this a change? Y N

Urinary:

Pain on urination	Y	N	P
Increased frequency	Y	N	P
Frequency at night	Y	N	P
Dribble urine	Y	N	P
Frequent infections	Y	N	P
Kidney stones	Y	N	P

Female reproductive:

Ave. # of days from start of menses to menses__
days you bleed _______

Regular cycles	Y	N	P
Skipped cycle(s)	Y	N	P
Breakthrough bleeding	Y	N	P
Freq. vaginal infections	Y	N	P

Breasts:

Lumps	Y	N	P
Pain or tenderness	Y	N	P
Nipple discharge	Y	N	P

Male reproductive:

Hernias	Y	N	P
Testicular lump	Y	N	P
Testicular pain	Y	N	P
Prostate disease	Y	N	P

Musculoskeletal:

Joint pain/stiffness	Y	N	P
Arthritis	Y	N	P
Broken bones	Y	N	P
Osteoporosis	Y	N	P
Muscle spasms/cramps	Y	N	P
Muscle weakness	Y	N	P
Loss of coordination	Y	N	P

Peripheral vascular:

Blood clots	Y	N	P
Anemia	Y	N	P
Easy bleeding/bruising	Y	N	P
Varicose veins	Y	N	P
Cold hands/feet	Y	N	P
Raynauds disease	Y	N	P

Neurologic:

Head injury	Y	N	P
Stroke	Y	N	P
Loss taste or smell	Y	N	P
Fainting	Y	N	P
Paralysis	Y	N	P
Numbness or tingling	Y	N	P
Seizures	Y	N	P
Memory loss	Y	N	P
Loss of balance	Y	N	P

Endocrine:

Hyperthyroid	Y	N	P
Hypothyroid	Y	N	P
Heat/cold intolerance	Y	N	P
Diabetes	Y	N	P
Excessive thirst	Y	N	P
Excessive hunger	Y	N	P
Excessive urination	Y	N	P
Excessive fatigue	Y	N	P

Emotional:

Depression/sadness	Y	N	P
Mood swings	Y	N	P
Feel out of control	Y	N	P
Feel stressed out	Y	N	P
Feel nervous	Y	N	P
Indecisive	Y	N	P
Feel isolated	Y	N	P
Uncontrolled anger	Y	N	P
Feel afraid	Y	N	P
Loss of self-esteem	Y	N	P
Feel victimized	Y	N	P
Anorexia/bulimia	Y	N	P
Enjoy your work	Y	N	P
Take vacations	Y	N	P
Spend time outdoors	Y	N	P
Exercise routinely	Y	N	P

What forms? ______________________________
How often_______________________________

Use tobacco, how much________	Y	N	P
Drink alcohol, how much ______	Y	N	P
Treated for alcoholism	Y	N	P
Use recreational drugs ___________	Y	N	P
Treated for drug abuse	Y	N	P

Diet:
Do you eat three meals daily? Y N
Blood Type? A B AB O unknown

Glasses of water per day? ____
Do you drink caffeinated products? Y N
If so, what kind? __________________________

Habits:

Does your child watch tv? Y N How many hours per day? ____________________________________
____

Does your child read? Y N How many hours per day? ____________________________________
____

Play video games? Y N How many hours per day? ____________________________________
____

Does your child do sports? Y N What kind and how many hours per week? _____________________
____

Day care/school/home school (circle) Grade level? ____
____

What are your child's favorite activities? ____
____
____

Anyone in your house smoke? Y N Even if they don't smoke around your child.

Are there pets in the home? Y N What kind? ____

Social History:

Whom does the child live with? ____

Are the parents divorced/separated? Y N

If so, what if any arrangements are made with other parent (eg. Visitation)? _________________
____

How would you describe the child's...

Personality? ____

Intelligence? ____

Temper? ____

Sociability? ____

Anything not covered in this questionnaire that you feel is important for your doctor to know about? ___
____
____
____

Signature: ____Date:________

Relationship to patient: ____

Thank you! I look forward to working with you and your family. Please feel free to ask any questions

Informed Consent and Request for Naturopathic Medical Care

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Kristina Olson-Kuyper ND, having had the opportunity to discuss the potential benefits, risks and hazards involved.

I,____________________________, hereby request and consent to examination and treatment with
Naturopathic Medicine with Dr. Kristina Olson-Kuyper and/or other licensed doctors of naturopathic medicine or licensed acupuncturists serving as backup for her,
hereafter called *allied health care provider*.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Kristina Olson-Kuyper and/ or with the *allied health care provider* providing backup:

(1) my suspected diagnosis(es) or condition(s)
(2) the nature, purpose, goals and potential benefits of the proposed care
(3) the inherent risks, complications, potential hazards or side effects of treatment or procedure
(4) the probability or likelihood of success
(5) reasonable available alternatives to the proposed treatment procedure
(6) potential consequences if treatment or advice is not followed and/ or nothing is done

I understand that a Naturopathic evaluation and treatment may include, but are not limited to:

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Common diagnostic procedures (including venipuncture, pap smears, diagnostic imaging, laboratory
- Evaluation of blood, urine, stool and saliva)
- Soft tissue and osseous manipulation (including therapeutic massage, deep tissue massage, neuro-muscular technique, naturopathic/osseous manipulation of the spine and extremities, pregnancy massage (to relieve muscular discomfort associated with pregnancy), muscle energy technique and cranio-sacral therapy)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra- muscular vitamin injections)
- Trigger point injection therapy with vitamin substances
- Botanical/ herbal medicines, prescribing of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, tropical creams, pastes, plasters, washes or other forms.
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water, may include transcutaneous electrode stimulation)
- Counseling (including but not limited to visualization for improved lifestyle strategies)
- Over the counter and prescription medications (including only those medications on the Formulary of Washington Naturopathic Physicians)

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor and any treatment intended to induce labor requires a signed letter from a primary care provider authorizing or recommending such treatment.

Notice to individuals with bleeding disorders, pace makers, and/ or cancer. For your safety it is vital to alert your provider, Dr. Kristina Olson-Kuyper of these conditions.

Please INITIAL the following:
________I understand that Dr. Kristina Olson-Kuyper is not licensed to prescribe any controlled substances.
________I understand that Dr. Kristina Olson-Kuyper , will only prescribe medications if she believes that they are in the best interest of myself, the patient. Appropriate referrals will be provided to manage my prescriptive medication needs.
________I understand the US Food and Drug Administration has not approved nutritional, herbal and homeopathic substances; however these have been used widely in Europe, China and the USA for years.
________I understand that Dr. Kristina Olson-Kuyper is not a psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies.
I do not expect Dr. Kristina Olson-Kuyper, and/or any *allied health care provider* to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request Dr. Kristina Olson-Kuyper explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

Printed Name of Patient	Signature of Patient	Date

Printed Name of Guardian	Signature of Guardian	Date

HIPAA Notice of Privacy Practices and Consent/Written Acknowledgement

I hereby consent to the use and disclosure of my protected health information by
Sweet Pea Family Medicine/ Dr. Olson-Kuyper ND
for the purposes of **treatment**, **payment and healthcare operations**, or as otherwise required by law.

- I acknowledge that I have a right to review or receive a printed copy of the Notice of Privacy Practices provided by ***Sweet Pea Family Medicine/ Dr. Olson-Kuyper ND*** prior to signing this consent. The Notice of Privacy Practices describes how medical information about me may be used and disclosed, and how I can access this information.
- I have the right to request restrictions to the usage and disclosure of my protected health information.
- I have the right to request an alternative to the standard method of communication of my protected health information.
- I understand that if I wish to revoke this consent at any time I will do so in writing and submit to the address listed below. I understand that ***Sweet Pea Family Medicine/ Dr. Olson-Kuyper ND*** may honor these requests, they are not required by law to do so. I also understand that revocations will be honored as of the date they are received by ***Sweet Pea Family Medicine/ Dr. Olson-Kuyper ND*** at the following address:

  3225 California Ave SW
  Seattle, WA 98116
- I understand that if I have any questions or complaints I may submit them in writing to the address above or contact ***Sweet Pea Family Medicine/ Dr. Olson-Kuyper ND*** by phone at: (206) 567-6729
- I am aware that ***Sweet Pea Family Medicine/ Dr. Olson-Kuyper ND*** reserves the right to change the terms of their Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, ***Sweet Pea Family Medicine/ Dr. Olson-Kuyper ND*** will make available a revised Notice of Privacy Practice for my review.

____________________________ __________________
Patient (18 years or older) Date

____________________________ __________________
Parent, Guardian, Responsible Party Date

THIS SECTION IS TO BE COMPLETED BY *Sweet Pea Family Medicine/ Dr. Olson-Kuyper ND* IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ]Patient declined to sign this written Acknowledgement
[ ]Other (specify):

Name and title of employee
Date

PERSONAL IDENTIFICATION INFORMATION

Please be aware that you do NOT have to provide your social security number as a form of personal identification to receive health care, UNLESS you are requesting us to bill your medical insurance carrier who requires your social security number for claim billing/reimbursement processes. In compliance with state and federal guidelines, ***Sweet Pea Family Medicine/ Dr. Olson-Kuyper ND*** does require a front and back copy of your state drivers' license to be on file for both medical and billing services.

I have fully read and understand the above terms for personal identification information.

Patient (18 years or older ______ Date ______

Parent, Guardian, Responsible Party ______ Date ______

NON-COVERED SERVICES WAIVER/ACKNOWLEDGEMENT

MEDICARE / MEDICAID
<u>I understand and agree to the following:</u>

- It is my full responsibility to inform staff and providers of ***Sweet Pea Family Medicine/ Dr. Olson-Kuyper ND*** that I am a Medicare and/or Medicaid member ***prior to*** scheduling an appointment or receiving services.
- Medicare currently does not recognize, contract with, or cover alternative care (CAM) providers; any services provided to me or charges incurred by me as a Medicare member are my full financial responsibility.
- ***Sweet Pea Family Medicine/ Dr. Olson-Kuyper ND*** is not contracted with any Medicaid plans; any services provided to me or charges incurred by me as a Medicaid member are my full financial responsibility.
- If I am a both a Medicare and Medicaid member and choose to receive services at ***Sweet Pea Family Medicine/ Dr. Olson-Kuyper ND***, I am fully aware that payments for any services, supplements, supplies, etc. are my full financial responsibility and **these charges *cannot* be billed** by either me or ***Sweet Pea Family Medicine/ Dr. Olson-Kuyper ND*** to Medicare or Medicaid.

OTHER SERVICES/SUPPLEMENTS/SUPPLIES
<u>I understand and agree to the following:</u>

- Any and all supplements, supplies, herbs, formulas, etc. prescribed by my provider and/or purchased by me at ***Sweet Pea Family Medicine*** are my full financial responsibility with payment to be made at the time of service/purchase. No open products can be returned to the clinic for refund under any circumstances.
- ***Sweet Pea Family Medicine/ Dr. Olson-Kuyper ND*** does not bill insurance carriers, health saving plans or any other like entities for any supplements, herbs, formulas, or supplies. It is my full responsibility to submit the required information to these entities for reimbursement.
- Treatment/services such as moxa, cupping, hydrotherapy, energy work, injections, IV therapy, etc. are generally not covered by insurance carriers and are my full financial responsibility *(except where specifically determined by my insurance carrier as included in the primary treatment/service being rendered and clearly stated in the insurance contract with the treating provider)*.
- It is my full financial responsibility to pay for any charges previously covered/paid by my insurance carrier to the ***Sweet Pea Family Medicine/ Dr. Olson-Kuyper ND*** which: **1)** is later deemed by my insurance carrier to not be "medically necessary", and **2)** has resulted in a partial or full refund request by my insurance carrier from the ***Sweet Pea Family Medicine/ Dr. Olson-Kuyper ND***.

I have fully read and understand the above agreements and information.

______________________________ ______________
Patient (18 years or older) Date

-______________________________ ______________
Parent, Guardian, Responsible Party Date

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand and agree to the following general responsibilities:

- Financial options extended to me are based on the personal identification information and documentation I have provided.
- I am responsible as the patient or patient's guarantor for full payment of services rendered at the time of service, including all supplements, herbal formulas, supplies, lab work and tests, and physician ordered add-on lab work and tests, as well as any additional expenses incurred in connection to my healthcare, such as: postage and delivery, shipping and handling, and phone calls to the provider or clinic wherein medical advice is provided.
- I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize ***Sweet Pea Family Medicine/ Dr. Olson-Kuyper ND*** to release information necessary to secure payment.
- When you schedule an appointment with us, we dedicate that time to you or your child. Please arrive on time to enjoy our full visit together! If you arrive early and we are still with another patient, please wait in the waiting area. We will be with you as soon as possible. **Late Policy**
- As stated above, the time scheduled for your appointment is dedicated to you or your child. If you cannot avoid arriving late, please call us so we don't worry about you! We can discuss our options by phone or when you arrive. Depending on the length of the scheduled visit and the time until the next appointment, we may decide to proceed with the appointment. However, the appointment must end on time so we can continue with the day's schedule! If we decide to reschedule for a different day, this will be considered a cancellation and you will be charged a $75 cancellation fee.
- **Cancellation Policy**
- In the event you need to cancel your your or your child's appointment, please call us at least 24 hours in advance so we can offer your time to another patient. If you do not make an effort to notify us at least 24 hours beforehand, you will be charged a $75 cancellation/ no show fee.but that late cancellation/missed appointment fees may vary dependent upon individual providers. Please ask your provider about his/her late cancellation and missed appointment fees or ask the front desk staff for further clarification.
- Fees and rates are adjusted periodically and therefore may increase during the term of our engagement. While we will do our best to avoid unknown adjustments, on occasion such changes may occur without written notice.

I understand and agree to the following with regards to current and/or future insurance billing:

- The verification of my health, motor vehicle accident, or workers' compensation insurance is used to determine if there is coverage for services through my insurance carrier and is NOT a guarantee of payment by my insurance carrier; I am fully responsible for being aware of any coverage exclusions.
- I am responsible for providing in a timely manner all accurate, current and thorough information and documentation required to verify my insurance coverage and/or bill my insurance carrier, including all relevant Coordination of Benefits information such as primary and secondary insurance, Medicare, Medicaid, etc.

- I understand that ***Sweet Pea Family Medicine/ Dr. Olson-Kuyper ND*** can require presentation of proof of insurance at any time, and that my insurance may need to be re-verified for specific coverage details with a minimum frequency of every 6 months.
- I am responsible for full payment of all services if any of the information I have provided is incorrect, falsified, or not provided in a timely manner and has resulted in ***Sweet Pea Family Medicine/ Dr. Olson-Kuyper ND*** inability to directly bill for and/or receive reimbursement from my insurance carrier.
- I am responsible for full and timely payment of all insurance co-pays, deductibles, and co-insurance balances due, including any and all services not covered or paid by my insurance carrier (subject to individual provider insurance contract provisions).
- I may forfeit the privilege of billing my insurance carrier if I do not comply with any of my financial responsibilities or documentation requirements.
- I authorize release of information in my medical history to my insurance carrier and assign all benefits for unpaid services to ***Sweet Pea Family Medicine/ Dr. Olson-Kuyper ND***. This release applies to support of the insurance billing processes only. Separate authorization may be required for other entity requests.

I have fully read and understand the above agreements and authorizations.

____ ____________

Patient (18 years or older) Date

-____ ____________

Parent, Guardian, Responsible Party Date

Sweet Pea Family Medicine
Dr. Kristina Olson-Kuyper ND

ASSIGNMENT OF BENEFITS

PATIENT NAME:____
(First & Last Name)

DATE OF BIRTH: ________________________________

INSURANCE ID: _________________________________ GROUP #:_____________________________

RELATIONSHIP TO INSURED: SELF SPOUSE CHILD

NAME & DATE OF BIRTH OF INSURED (IF NOT SELF): _______________________________________

____

I request that authorized insurance payments be made on my behalf to Sweet Pea Family Medicine/ Dr. Kristina Olson-Kuyper ND for any services furnished me by provider or supplier. I authorize the release of any medical information requested about me that is necessary to determine benefits, payable or otherwise, for related services.

____ ___________________________________

Signature Date Signed

P: 206-567-5629
F: (844) 580-2720
3225 California Ave SW
Seattle WA, 98116
www.sweetpeafm.com
Tax ID# 45-3659432 / NPI # 1598041824

Insurance Verification Form

Subscriber Name: ____
Patient Name: ____________________________ DOB: _________________
Insurance Company: ____
Insurance ID#: ____
Group ID#____

Sweet Pea Family Medicine provides courtesy insurance billing. It is up to you, the patient/representative/guardian, to determine insurance coverage. In order to ensure you are aware of your benefits, we request that you go through the following procedure before your visit. If you do not have insurance coverage, payment is due in full at time of service. We offer a discounted rate to patients who pay at the time of service and those who wish to bill insurance directly themselves.

It is the patient's responsibility to be aware of his/her coverage, as well as any deductible and maximums. If insurance denies payment for any reason, the patient is responsible for the full balance within 30 days of receiving a bill.

You may be asked for the following identification numbers:
Tax ID Number: 45-3659432

NPI Number: 1598041824

Please follow the steps below to find out your benefits and eligibility.

First, call the number on your insurance card listed for customer service, benefits and eligibility, or subscriber services, and ask the representative the following questions:

1. Do I have naturopathic coverage? **YES / NO**

2. Beginning date of coverage ___________.
   Ending date of coverage _____________.

3. What is my deductible for the year, and have I met any part of that deductible?
Yearly deductible ___________
Amount met _____________
When does it re-set? __________

4. Is my plan centered around on the calendar year? **YES / NO**
   If not, what is my plan year (ex: Sept-Aug)? _________________

5. Do I need a referral from my primary care physician (PCP) for alternative services? **YES / NO**

6. Is Dr. Kristina Olson-Kuyper an In-Network or a preferred provider for my insurance plan? **YES / NO** *If no, skip to question #7.*

6a. For an In-Network doctor, I have _________% coverage
   or $________ co-pay.

7. Is the doctor I want to see covered as an Out-of-Network Provider? **YES / NO**

7a. For an Out-of-Network doctor I have ___________% coverage or $___________ co-pay

8. What are my benefits for the following services?

Be sure to find out the benefits that apply to the doctor you are seeing; there will be different benefits depending upon whether the doctor is IN or OUT of Network with your insurance company and whether your plan includes Out-of-Network benefits.

Naturopathic care: % Covered:________
Co-Pay/Co-Insurance_______ Year Max_______
Ultrasound: % Covered:________
Co-Pay/Co-Insurance_______ Year Max_______
Chiropractic: % Covered:________
Co-Pay/Co-Insurance_______ Year Max_______
Acupuncture: % Covered:________
Co-Pay/Co-Insurance_______ Year Max_______
Massage: % Covered:________
Co-Pay/Co-Insurance_______ Year Max_______

Home Visits: Are the following CPT codes covered by your insurance?

- 99461 Newborn follow up home visit
- 99343 Moderate severity home visit New Patient
- 99349 Moderate severity home visit established patient

9. Are any of the specialties listed above subject to deductible?
YES / NO
If so, which ones? ____

Name of insurance representative I spoke with:
____ Date: ___________________

Please be aware that this is not a guarantee of payment. If an insurance company gives you inaccurate information, they may not honor the benefits that were quoted.

Please initial next to the following:
______ I have verified my insurance benefits and listed them above.
______ I understand that insurance billing is provided as a courtesy, and that I am responsible for all claims unpaid by my insurance company.
______ I agree to be billed for any amount not paid by my insurance, and will submit payment to my physician within 30 days of receiving a bill. (Payment may be made by cash, check, or credit card.)

Name: ____
(Please print. Include parent / guardian name if patient is a minor)

Signature: ____Date: ______/______/______
(Parent or guardian if patient is a minor)