

Tree of Health Integrative Medicine, LLC

Eleonora Naydis, N.D., L.Ac

17220 127th Place NE, Suite 200,
Woodinville, WA 98072
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10564 5th Avenue, Suite 103
Seattle, WA 98125
Phone: (206) 361-2255

Patient Information

Last Name: _____ First Name: _____ MI: _____

Other names: _____ Date of Birth: _____ SS#: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____ E-mail: _____

Home phone: _____ Work phone: _____ Cell phone: _____

May we leave confidential voice-mail messages for you at any of the above numbers? _____

Sex: _____ Marital status (Circle one): Single Married Long-Term Partner Divorced Separated Widowed

Occupation: _____ Employer/School: _____

Mother's Name (minors only): _____

Father's Name (minors only): _____

Emergency Contact: _____ Contact's Phone #: _____

Emergency Contact is my: (specify relationship) _____

Family Physician: _____ Phone number: _____

How did you hear about us? (Circle One): Friend Family Medical Referral Newspaper ad Brochure Flyer Website Yellow Pages Insurance Co. Other _____

Insurance/Guarantor Information

Primary Insurance Company & Plan Name: _____ ID Number: _____

Group/Policy Number: _____ Name of Policy Holder: _____

Policy Holder's Date of Birth: _____ Policy Holder's Employer: _____

Policy Holder's Gender: _____ The policy holder is my: _____ (specify relationship)

Secondary Insurance Company & Plan Name: _____ ID Number: _____

Group/Policy Number: _____ Name of Policy Holder: _____

Policy Holder's Date of Birth: _____ Policy Holder's Employer: _____

Policy Holder's Gender: _____ The policy holder is my: _____ (specify relationship)

Guarantor Information: (If someone other than the patient is responsible for patient's account)

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____ Phone: _____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X _____
Guarantor's Signature

Date

Financial Policy and Authorization to Bill Insurance

- Each patient should check with Member Services at their insurance plan to understand their specific benefits. Patients not utilizing insurance will be asked for payment at the time of their appointment.
- I understand that if I am providing insurance billing information that I am responsible for all charges whether or not they are covered by my insurance. Co-pays and charges for dispensary items are due at the time of the visit.
- I understand that there is a cancellation policy and that I may be billed for missed appointments or appointments cancelled with less than 24 hours notice.
- I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month.
- I understand that any guarantor who is financially responsible for my account is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.
- I understand that some third-party payers (insurances) may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Eleonora Naydis, N.D., L.Ac. to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

X _____
Patient's Signature Date

X _____
Guardian/Representative's Signature and Relationship Date

Privacy Policy

- We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so.
- Tree of Health Integrative Medicine, LLC is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish schedule an appointment to view your medical record, please contact Eleonora Naydis, ND, LAc at (425) 488-3411 or (206) 361-2255.
- I hereby acknowledge that I have received a copy of Tree of Health Integrative Medicine, LLC's Notice of Privacy Practices. Should I fail to sign this form, I acknowledge that Tree of Health Integrative Medicine, LLC has made a good faith effort to obtain my acknowledgement.

X _____
Patient's Signature Date

X _____
Guardian/Representative's Signature and Relationship Date

Consent for Treatment

I, the undersigned, hereby authorize Eleonora Naydis, N.D., L.Ac. (MSA – 6/2004 from Bastyr University, acupuncture license # AC00002557), to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

General Diagnostic Procedures, which may include but not limited to venipuncture, pap smears, radiography, and blood and urine lab work, general physical exams, neurological and musculoskeletal assessments.

Lifestyle Counseling and Hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, immunization, psychological counseling, and balancing of work and social activities.

Dietary Advice and Therapeutic Nutrition: use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.

Herbs/Medicines: prescribing various therapeutic substances including plants, minerals, animal materials, and some pharmaceuticals, and contraceptive devices. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical creams, pastes, plasters, washes, suppositories or other forms.

Soft Tissue and Osseous Manipulation: use of massage, cupping (a technique to relieve symptoms in which cups made of glass or other materials are placed on the skin with a vacuum created by heat or other device), gua sha (a rubbing on an area of the body with a blunt, round instrument), neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy.

Homeopathic Remedies: use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.

Minor office procedures: e.g., dressing a wound, ear cleansing, care of superficial lacerations.

Electromagnetic and Thermal Therapies, which may include the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, infrared and ultraviolet therapies, moxibustion (burning on an acupoint using stick, string, or ball moxa) and hydrotherapy.

Acupuncture: insertion of special sterilized needles through the skin into underlying tissues at specific points on the surface of the body. Sometimes electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians may be used

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: Discomfort, pain, minor bruising, infection, blistering, broken needle, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements, soft tissue or bone injury from physical manipulations, temporary discoloration of the skin, temporary dizziness and lightheadedness, and aggravation of pre-existing symptoms.

Potential benefits: Drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem and the strengthening of the constitution, restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: Labor-stimulating acupuncture points are not used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care or pre-natal care provider authorizing or recommending such a treatment. All female patients must alert the practitioner if they know or suspect they are pregnant.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by [Eleonora Naydis, N.D., L.Ac.](#) regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or if it is required or permitted by applicable law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last treatment. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of [her](#) ability.

Patient's Name (Print)

Guardian's Name (Print)

Patient's Signature

Guardian's Signature

Date

Relationship to Patient

Date

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Confidential Health Questionnaire

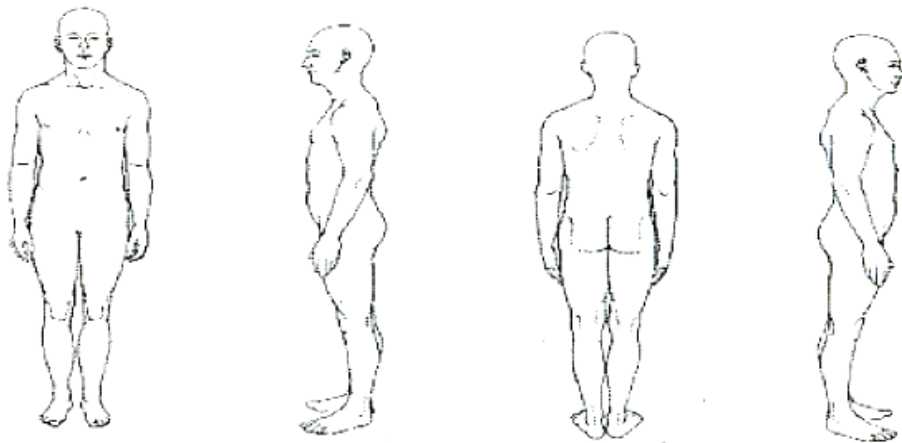
Please, fill out the following information as accurately as possible. This information will help the doctor with diagnosis and treatment plan.

Please, list specific health concerns in the order of importance to you:

Health concern	Date started	Diagnosis given	Treatments received

Do you have any insights about your health concerns? _____

Please, draw the location of your discomfort:



Please, list all prescription medications, over-the-counter medications, and supplements you are taking:

Medication, OTC, or Supplement	Dosage	Taking for	Doctor (if prescribed)

List any Hospitalizations & Surgeries Date Place

Do you have any specific health goals?

Are you allergic to any medications, foods, or environmental factors?

Do you smoke? _____ How much? _____ For how long? _____ Did you ever try to quit? _____

Do you use any of the following? Coffee _____ Soda _____ Alcohol _____ Recreational drugs _____

Do you exercise? _____ Please, describe _____

Date of last physical exam _____ Date of last blood work _____ Date of last dental exam _____

Do you do any form of deep relaxation? _____ What kind? _____

Do you have any dietary restrictions? (Specify) _____

24 hour diet recall: (please record food and drink you have had within past 24 hours)

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks _____

Past Medical and Family History: Please indicate whether you or a family member have had in the past or is currently affected by any of the conditions listed below. Please, indicate self or a relationship to you in the Relation column.

Condition	Relationship to you	Past (P) or Current (C)	Condition	Relationship to you	Past (P) or Current (C)
Anemia			Heart disease		
Alcoholism or drug addiction			Hepatitis		
Allergies			High blood pressure		
Arthritis			High cholesterol		
Asthma			HIV		
Autoimmune disease			Kidney disease		
Cancer			Mental illness		
Depression			Stroke		
Diabetes			Thyroid disease		
Eczema			Tuberculosis		
Epilepsy			Venereal disease (STD)		
Headaches			Other		

Review of Systems: Please, indicate whether you have had any of the following (P = past, C =current). If your condition is not listed, please, add below.

	Past or Current		Past or Current		Past or Current
General					
Fatigue		Hot flashes		Weight loss ____ lbs	
Fever		Poor appetite		Weight gain ____ lbs	
Night sweats		Food cravings		Water retention	
Thirst		Peculiar taste/smell		Weak immune system	
Bleed/bruise easily		Poor sleep		Dizziness	
Other					
Skin and hair					
Dandruff		Dry skin		Acne	
Itching		Open sores		Eczema	
Rashes		Poor healing		Hair loss	
Psoriasis		New moles			
Other					
Head, Eyes, Ears, Nose and Throat					
Poor vision		Night blindness		Spots in front of eyes	
Ringin in the ears		Poor hearing		Earaches	
Sinus problems		Eye pain		Teeth grinding	
Nasal congestion		Color blindness		Hoarseness	
Recurrent sore throat		Facial pain		Headaches Where _____	
Nose bleeds		Vertigo		Head trauma When _____	
Other					
Cardiovascular					
	Past or Current		Past or Current		Past or Current
Chest pain		Low blood pressure		Palpitations	
High blood pressure		Pace maker		Chest pain	
Irregular heart beat		Swelling of hands/feet		Bleeding disorder	
Blood clots		Cold hands/feet		Varicose veins	
Other					

Respiratory					
Cough		Coughing blood		Difficulty breathing lying down	
Bronchitis		Asthma		Post nasal drip	
Pneumonia		Pain with deep breath		Snoring	
Emphysema		Other			
Gastrointestinal					
Change in bowel habits		Blood in stools		Colitis	
Constipation		Rectal pain		Ulcer	
Diarrhea		Bloating		Hemorrhoids	
Abdominal pain		Heartburn			
Other					
Genitourinary					
Pain on urination		Urgent urination		Incontinence	
Frequent urination		Infections		Decrease flow of urine	
Blood in urine		STD		Cystitis	
Kidney stones		Change in libido		Other	
Males					
Prostate problems		Impotency		Infertility	
Abnormal sperm analysis		Other			
Females					
Number of pregnancies		Infertility		Irregular periods	
Number of births		Endometriosis		Heavy menstrual flow	
Number of miscarriages		Age at 1 st menstruation		PMS sx What kind _____	
Number of abortions		Time between periods		Vaginal discharge	
Number of premature births		Duration of periods		Vaginal sores	
Difficulty conceiving		First day of last period		Bleeding in between periods	
Birth control		Menopause Age _____		Uterine fibroids	
Currently pregnant		Breast lumps		Painful periods	
Currently breast-feeding		Date of last mammogram _____		Other	
Musculoskeletal					
Neck pain		Knee/ankle/foot pain		Metal implants	
Back pain		Hip pain		Tingling	
Arm/hand/wrist pain		Shoulder pain		Numbness	
General muscle pain		Other			
Neuropsychological					
	Past or Current		Past or Current		Past or Current
Seizures		Easily stressed		Loss of balance	
Lack of coordination		Poor memory		Anxiety	
Depression		Difficulty concentrating			
Other					

Comments:
