Michael Woo, ND, LAc
Pacifica Natural Medicine
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Thank you for scheduling a First Office Consultation with us. We look forward to seeing you on________________________.

I am pleased that you have chosen Naturopathic Medicine and/or Acupuncture as another option for your health care needs. I am a firm believer in Natural Medicine because I have seen firsthand the innate healing power of the body and the success of natural healing modalities. I am licensed by the State of Washington as a primary care provider in Naturopathic Medicine and a Licensed Acupuncturist and do carry malpractice insurance.

Please complete the attached forms and bring them with you to your appointment. We have scheduled your first visit for 90 minutes. If you must cancel or reschedule this appointment, please call me at the above telephone number at least 24 hours in advance. Appointments cancelled with less than 24 hours notice and/or no-shows will result in a $75 fee.

Please also bring copies of any recent or pertinent lab work results, imaging reports or treatment plans from your current or previous health practitioner. If you do not have hard copies in your possession, we can request these during your visit.

I am currently an authorized provider under Premera, United Health, Cigna, First Choice, Aetna, Regence, Lifewise, Moda, and Blue Cross/Blue Shield. Even though I may be in their system, your actual plan specifics may not cover some of our services. It is highly recommended to check your benefits with your insurance company before coming in. We have included a form with a list of questions to ask your insurance provider about your specific benefits and coverage. We will take a copy of your insurance card and your credit/HSA card, and if applicable, receive any payment due at the time of your appointment. Payments can be made with check, credit/debit card, HSA card or cash.

I look forward to meeting and working with you. Please call with any questions or concerns.

Dr Michael Woo, ND, LAc

Michael K. Woo, ND, LAc.

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Out of respect for our chemically sensitive patients, we request that you do not wear perfume, cologne, aromatic oils, or other scented products into this office. Thank you!

This form is completely confidential. This information cannot be given to anyone outside this office without your written permission. Thank you for answering all questions completely.

Today's Date____________________

Name__________________________________ Date of Birth_______________ Age______ Gender______

Address_________________________________ City____________________ State______ Zip_________

Home # (_____)_______________ Work # (_____)_______________ Cell # (_____)________________

Fax # (______)_______________ E-mail ____

Spouse or significant other, Work # (______)__________________ Cell # (______)__________________

You live with: _______Spouse _______Partner _______Parent(s)

_______Child(ren) _______Friend(s) _______Pets

Names of persons you live with:____

Occupation(s)_____________________________________Hours per week________ Retired?_________

Employer___________________________________

How did you hear about our clinic?____

Has another family member already been a patient at the clinic? ____________________________________

Person responsible for bill, if not the patient: _____________________ Relationship__________________

Address____ Phone (______)____________________

Person to Contact in Case of Emergency:

Name______________________________Relationship______________ Phone (_____)________________

Address__________________________________City________________State _______ Zip___________

HEALTH QUESTIONNAIRE

A successful health care team includes a patient who is committed to making and maintaining needed changes and a compassionate, dedicated physician who thoroughly understands the patient- physically, mentally, and emotionally. To help us in this process, please complete this questionnaire as thoroughly as possible. Please print legibly, and mark anything you do not understand with a question mark.

What are your most important health problems? List as many as you can, in order of importance.

1.______________________________________ 6.______________________________________

2.______________________________________ 7.______________________________________

3.______________________________________ 8.______________________________________

4.______________________________________ 9.______________________________________

5.______________________________________ 10.______________________________________

What are your goals for today's visit? Please list in order of importance.

1.______________________________________ 3.______________________________________

2.______________________________________ 4.______________________________________

How much change are you willing to make at this time to improve your health?

______25% ______50% ______75% ______100%!

Allergies (include environmentals, animals, food, chemicals, drugs): Type of reaction:

__________________________ ____

__________________________ ____

__________________________ ____

Please list other health care practitioner(s) who help you manage your health: (Please include their name and type of practitioner and their phone #)

________________________ ______________________________ (_____)________________

________________________ ______________________________ (_____)________________

________________________ ______________________________ (_____)________________

Your HEALTH HISTORY (Please check the relevant areas and give details below)

______Alcoholism	______Diabetes	______Liver Disorder
______Allergies	______Gout	______Psychological Disorder
______Anemia	______Heart Disorder	______Skin Disorder
______Arthritis	______Herpes Genitalis	______Stroke
______Asthma	______High Blood Pressure	______Thyroid Disorder
______Cancer	______Hypoglycemia	______Tuberculosis
______Colitis	______Injury	______Venereal Disease

Details of above or other problems: ____

____

____

Hospitalizations (date and type of illness / operation): ____

____

____

Current Medications/ Supplements/ Drugs: Do you take or use?

Laxatives	Y N	Thyroid Medication	Y N	Sleeping Aids	Y N
Cortisone	Y N	Hormone Replacement	Y N	Appetite Suppressants	Y N
Tranquilizers	Y N	Antacids	Y N	Birth Control Pills	Y N
Pain Relievers	Y N	Antibiotics	Y N		

Please list any and all prescription medications, over the counter medications, vitamins, herbs and stimulants. Example:

Name of product	Brand	Dose/ frequency	For how long have you been taking?
Vitamin C	Pure Encapsulations	1000mg. 3x/day	1 month

(Add additional pages if necessary)

Do you have any adverse (or opposite) reactions to medications? ______________________________________

____

____

Do you have to reduce recommended doses of medications to avoid adverse effects? ____________________

____

Have you ever used recreational drugs? Y N If so, what kind, and how often? ______________________

____

Have you ever used tobacco? Y N If so, what kind, how much and for how long have you used it?

____

Do you still use tobacco? Y N Are you exposed to tobacco at home? work? Y N

Do you drink alcohol? Y N If so, how much? ____

Do you drink coffee? Y N If so, how much? ____

Does caffeine strongly affect you? Y N What reactions do you have? ______________________________

If you have caffeine in the afternoon, do you have problems sleeping at night? Y N

Do you drink water? Y N If so, how much? _______________ Source? ___________________________

Do you handle stress well? Y N What do you do to handle stress? _______________________________

Do you get regular exercise? Y N If so, what form, and how often? ______________________________

____

Do you feel better or worse after exercise? ____

What are your primary interests, hobbies, or activities? ____

____

Family Health History

(Please note any significant problems for the following blood relatives)

Father______________ Father's Mother____________ Father's Father___________________

Mother______________ Mother's Mother____________ Mother's Father__________________

(1) Brother ___________ (2) Brother________________ (3) Brother______________________

(1) Sister ____________ (2) Sister_________________ (3) Sister_______________________

(1) Child_____________ (2) Child__________________ (3) Child________________________

List any foods that you crave: ____

How frequently do you eat these foods?____

Sleep Patterns

What time do you go to bed? ____________ How soon before you actually fall asleep? ________________

What time do you wake up? ______________ Do you feel refreshed in the morning?__________________

Do you wake during the night? Y N If so, what time? ________

How long before you get back to sleep? __________

Symptom Survey

Check the symptoms and characteristics which apply to you. Use "1" for mild, occasional symptoms; "2" for moderate, more frequent symptoms; "3" for severe, constant symptoms

Carbohydrate Metabolism and Allergies

(answer according to directions above)

_____ Eat when nervous
_____ Irritable before meals
_____ Get shaky if hungry
_____ Fatigue relieved by eating
_____ Migraine headaches
______Recurrent ear infection
_____ Sneezing attacks

_____ Heart palpitates
_____ Afternoon headaches
_____ Overeating sweets upsets stomach
_____ Hyperactivity
_____ Eczema
_____ Hay fever

_____ Crave candy or coffee
_____ Depression
_____ Alternating constipation & diarrhea
_____ Pulse speeds after eat
_____ Hives
_____ Sinus drainage

Liver

_____ Dry skin
_____ Itching skin & feet
_____ Frequent skin rashes
_____ Bitter metallic taste in mouth in morning

_____ Biliousness
_____ Greasy food upset
_____ Gallbladder problems
_____ Pain between shoulder blades

_____ Bad breath
_____ Milk products distress
_____ Burning or itching anus

Digestion

______ Lower bowel gas several hours after eating
______ Gas shortly after eating
______ Burning sensation that eating relieves
______ Coated tongue
______ Stool has foul odor
______ Indigestion ½ - 1 hour after eating
______ Colitis
______ Stomach bloating after eating
______ Painful bowel movements

Bowel movements occur how often? ____

Circulation

______ Hands & feet go to sleep easily, numbness
______ Cold hands and feet
______ Legs hurt after walking
______ Swollen ankles, worse at night
______ Frequent nose bleeds
______ Shortness of breath or exertion
______ Must prop self up on pillows at night
______ Bruise easily
______ Ringing in ears
______ Sigh frequently
______ Angina pains
______ Open windows in a closed room

Thyroid – Pituitary – Adrenal

______ Increase in weight
______ Decrease in appetite
______ Easily fatigued
______ Ringing in ears
______ Sensitive to cold
______ Mental sluggishness
______ Slow pulse, below 65
______ Sleepy during day
______ Reduced initiative
______ Insomnia
______ Intolerance to heat
______ Night sweats
______ Can't work under pressure
______ Abnormal thirst
______ Weight gain around hips or waist
______ Hair loss
______ Menstrual disorders
______ Menstrual disorders worse since childhood
______ Sex desire reduced or lacking
______ Nervousness
______ Highly emotional
______ Inward trembling
______ Increase appetite
______ Irritable and restless
______ Weakness, dizzy
______ Chronic fatigue
______ Lightheaded after standing
______ Craves salt
______ Wiped out by stress
______ Wake up tired
______ Can't gain weight
______ Flush easily
______ Heart palpitates
______ Eyelids and face twitch
______Pulse fast at rest

Females Only

______ Depression before menses
______ Craves sugar at menses
______ Painful breasts
______ Menses regular
______ Pain during intercourse
______ Use of birth control pills
______ Anxiety before menses
______ Painful menses
______ Breast lumps
______ Menses irregular
______ Vaginal Itching
______Water retention during menses
______Excessive Menses
______Vaginal discharge

Duration of period? ______________________ Frequency of periods? ________________________________

Number of pregnancies ________ Births __________Miscarriages __________ Abortions ________________

Type of birth control used: ___________________________ How long? ________________________________

Have you experienced menopause? ____________________ If so, what age?____________________________

Date of last Pap smear: ___________________________Age menses began: ___________________________

Do you do breast self- examinations? _______________ If so, how often? ____________________________

Date of last mammogram? __________________ Have you had a hysterectomy? ________________________

Male Only

_____Prostate Trouble

_____ Burning Urination

_____ Night Urination

_____ Feeling of incomplete bowel movement

_____ Urination difficult or dribbling

_____Difficulty with erection

Personal Dynamics

Describe your personal relationship dynamics at the time your illness started (stress, etc.) _______________

____

____

____

____

____

____

Briefly describe your family dynamics during your childhood and currently: ____________________________

____

____

____

____

____

____

Clinic Policies

Payment for Services, Laboratory Tests and Health Products: Payment is due at time of services. We accept cash, check and credit cards. There is a $25 charge for all returned checks.

Insurance Billing: We can bill most major insurances. However, it is your responsibility to know what your insurance covers or doesn't, including your deductible status. We have provided you with a list of questions to ask and confirm with your insurance provider. Please have this with you at your first appointment. ***We require a credit/debit/HSA card number on file if we are to bill your insurance. You will be asked for a card number at the time you check in and the information will be securely stored. When your portion of the bill is determined (denied coverage, copay, coinsurance, deductible or other outstanding balances) we will notify you before charging your card. A copy of your receipt will be provided.***

Records and Confidentiality: Your medical records are confidential and require your written authorization before they can be released.

Phone Consultations: Phone consultation appointments with the doctor are available for those who live out of state, are disabled, or have special circumstances that prevent you from traveling to our clinic. The phone consultation fee is $65 for Focused (approx 15 min), $110 for Expanded (~30min), $140 Detailed (~45 min) and $175 (~60min) for Comprehensive appointments. Please have your credit card ready before you call.

Appointment Cancellations: We understand that circumstances occasionally arise which may make it difficult to keep a scheduled appointment. You may cancel at no charge if you call at least 24 hours before your appointment. If you do not call to cancel and/or fail to show up for an appointment there will be a **$50 no-show fee** charged to your card. This fee is not covered by your insurance

Dispensary: Our prices are competitive with no sales tax charged for prescriptions. We carry only the products that have been selected for their purity and effectiveness. For your convenience please call ahead with your order and we will have it ready when you arrive or we can ship direct to your home.

I have read and understand these guidelines and agree to the terms therein.

Patient Name (please print)	Signature	Date

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Insurance Benefits and Coverage Questions to Ask Your Provider

Thank you for choosing to see us at our clinic. We understand that dealing with medical insurance companies is not an easy task. However, it is your responsibility to know and understand your coverage and its limitations as our office does not call for these details. As a courtesy, we have created this list of questions to assist you when asking about your insurance coverage and benefits. You are financially responsible for any remaining balances that your insurance does not cover. Please have this form with you and filled out for your first visit.

1. Do I have Naturopathic coverage?
   - What is my deductible? How much of this have I met and/or how much is left?
   - What is my co-pay?
   - What percentage does the insurance pay or what is my co-insurance?
   - Is there a maximum number of visits per year?
   - Is my plan based on a calendar year or a plan year?

2. Do I have Acupuncture coverage? (Similar questions as above)
   - Deductible? How much left?
   - Co-pay?
   - Co-insurance?
   - Maximum # of visits?

3. Do I have Lab Work and Imaging in-network coverage? Do I have out-of-network lab coverage?
   - Deductible? How much left?
   - Co-pay?
   - Co-insurance?
   - Repeat these questions if you also have out-of-network lab coverage

4. Do I have Physical Therapy or Physical Medicine coverage?
   - Deductible? How much left?
   - Co-pay?
   - Co-insurance?
   - Maximum # of visits?

Your insurance customer representative should be able to clarify and answer any other questions you may have regarding the details of your coverage.

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Advance Beneficiary Notice (ABN) of Insurance Non-Coverage

Name:______________________ **Insurance:** ____________________ **ID#:** ________________________

NOTE: We need you to make a choice about receiving these health care items and/or services.

- Please read this notice carefully so you may make an informed decision about your health care services at this clinic. Ask us any questions that you may have after reading this
- Ask us to explain if you do not understand why your insurance may not pay for these services and ask us how much these items may cost.

Your medical health insurance may not pay for all or any of your services listed below even though your medical provider has good reasons to recommend it. The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it. Right now your insurance company may not pay for:

Item and/or Service: Office Visit, Lab Tests, Acupuncture, Physical Therapy, Injections, Supplements

Due To: Lack of Coverage

The purpose of this form is to help you make an informed decision about whether or not you want to receive these services knowing that you may need to pay for them yourself. Please choose one option below, sign and date.

_____ Option 1: Yes, I want to receive these items and/or services. I understand that my insurance company will not decide whether to pay unless I receive these items/services. Please submit these claims to my insurance company and if they refuse/deny payment or if there are outstanding copay, coinsurance or other balances, I agree to be personally and fully responsible for the payments. That is, I will personally pay out of pocket or through any other insurance that I have. I understand I can appeal my insurance company's decision. **I will provide the clinic with my credit card or FSA/HSA card number to be stored securely and it will not be charged until I am notified by the office staff.**

_____ Option 2: Yes, I want to receive these items and/or services and will pay for these personally out of pocket. Please do not bill my insurance company. I understand that I cannot appeal if my insurance is not billed.

_____ Option 3: No, I have decided not to receive these items and/or services. I understand that you will not be able to submit a claim with my insurance company and I will not be able to appeal your opinion that my insurance company will not pay

____ ________________
Signature of patient or person acting on patient's behalf Date

Note: Your health information and any information that we collect about you on this form will be kept confidential. If a claim is submitted, your health information may be shared with your insurance company