Arbor Health Center
2025-112th Ave NE
Bldg. 2, Suite 300
Bellevue, WA 98004

Phone: 425-452-9366
Fax: 425-452-5683

Getting to Know You

PATIENT INFORMATION		
Name:		Date:
Date of birth:	Age:	Marital Status:
Legal Guardian/s (for minors):		
Current address:		
City:	State:	ZIP Code:
Cell:	Home:	Work:
Email:		May we use?
Employer:		Position:
Emergency Contact:		Relationship:
Cell:	Home:	Work:
How did you hear about us?		

INSURANCE INFORMATION		
Primary Insurance:		
Name on Insurance:		Relationship:
ID #:	Group #:	
Secondary Insurance (if applicable):		
Name on Insurance:		Relationship
ID#:	Group #:	

PHARMACY/MEDICAL INFORMATION	
Primary Care Provider:	
Facility:	Phone:
Specialist (if applicable):	
Facility:	Phone:
Are you seeing a chiropractor/massage therapist/acupuncturist? (circle) Y N	
If yes, who(m)?	
Preferred Pharmacy:	
Cross Road & City:	Phone:
Allergies to medications:	Blood Type:

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Financial Policies

Payment:

- All fees are due at the time of service. This includes services rendered, supplies/supplements received, or laboratory tests ordered.
- If you have health insurance that Dr. Wilkie is contracted with, we will bill your carrier directly. All co-payments, deductibles and balances are due at the time of service, and may be paid by cash, check or credit card.

Insurance:

- Dr. Wilkie is contracted with Premera Blue Cross, Regence Blue Sheild, First Chocie, and all their subsidiaries.
- While naturopathic physicians are covered by many insurance companies, each plan can differ widely. Our staff will make every effort to determine benefits and eligibility prior to treatment, but it is ultimately your responsibility to know your benefits, deductible, co-payments and exclusions.
- If you are unsure of your coverage, you may opt to pay for your visit in full at the time of service. We will then bill your insurance for that rate and will apply the amount to any outstanding balances, or refund you, whichever is your preference.
- If you are not covered by one of the above listed insurances, you must pay in full at the time of service. For your convenience, we can provide you with an insurance billing form that you can submit to receive payment from your insurance company.

Cancellations and Appointment Changes:

- Please give us at least 24 hours advance notice if you are unable to keep your appointment, or need to reschedule.
- We understand that "life happens." If the reason for cancellation/no-show involves a life-event or unforeseeable circumstances, let us know. If not, you will be charged a $50.00 charge.

Non-covered Services and Fees:

- Non-covered services are those for which insurance will not pay. These include telephone consults greater than 10 minutes in length, injections, Myers Cocktail infusions and functional lab tests.
- Labs: if you do not have insurance, you will need to pay for all labs drawn in-office. Dr. Wilkie will make every effort to accurately quote you an amount before she performs the draw. Some lab kits, as in food sensitivity kits, are prepaid to Dr. Wilkie at a discounted rate, as they are not covered by insurance.
- We charge $10 per month for patient balances that are not paid within 30 days.
- We charge $30.00 for returned checks.

I have read and understood these financial guidelines and policies. I have been offered a copy of this information, and agree to abide by these terms.

Printed Name: ______________________ Signature & date: ___________________________

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Consent To Treat
Privacy Policies

CONSENT TO TREATMENT

- I, the undersigned, hereby acknowledge that the care being provided by Dr. Vanessa D. Wilkie, ND is designed to improve my overall health or specific health condition.
- I authorize the doctor to:
  - Perform diagnostic tests deemed necessary for my care.
  - Perform any and all forms of treatment and therapy that are indicated and are in accordance with the Standards of Naturopathic Care. This can include, but is not limited to: prescribing medications and supplements, B-shot injections, Meyer's injections, and homeopathic preparations.
  - If procedures are performed, I have given my permission to do so and acknowledge that full disclosure of information has been made. I understand that every effort will be made by the doctor to fully disclose information about the procedures used. If I have questions about these procedures I will ask them until they are answered to my full satisfaction.
- I further acknowledge that there is no guarantee or warrantee, expressed or implied, concerning the outcome of any of the procedures used in the course of my care.
- If while under the doctor's care I experience a medical emergency, I am to dial 911, and when able, will call the office to report the outcome to Dr. Wilkie.

I understand and agree to the above Authorization for Treatment. I will abide by its terms.

PRIVACY POLICIES

- The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003.
- Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.
- Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov
- If you would like a copy of the complete document to read and review before consenting, please ask for one at the front desk.

If over 14, Patient's Printed Name: ______________________________

If a Child, Parent's Printed Name: ______________________________

Signature of Patient or Guardian: ____________________ Date: __________