BAY NATURAL MEDICINE

CONTACT INFORMATION Please print clearly.

Name: _____ Today's date: _____

Street address: _____

City, State, Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

_____
Which phone number would you like us to contact you with confidential information?
_____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Home/Cell Phone: _____ Alternative Phone: _____

PERSONAL INFORMATION

Date of birth: _____ Age: _____

Relationship status: Married/Partnered Single Divorced Widowed Number of children: ____
(circle one)

Occupation: _____ Hours worked: _____

Do you have insurance? If so, what type? _____

How did you hear about us? If on the internet, please name website: _____

HEALTH INFORMATION

Please list your 3 major health concerns.
1.

2.

3.

List all allergies and sensitivities (drugs, food, environmental, chemical).

BAY NATURAL MEDICINE

Please continue on the reverse side →

List all current or past medical diagnosis.

List all surgeries, hospitalizations, major accidents, x-rays and special procedures.

List all current medications.

Medication	What is it for?	Dosage	Frequency

List all current dietary supplements, herbs and over the counter medications.

Supplement	What is it for?	Dosage	Frequency

FAMILY MEDICAL HISTORY

Please list if any of your family members has had any medical diagnosis (i.e. hypothyroid, colon cancer, diabetes).

Mother	Father
Sister(s)	Brother(s)
Maternal grandmother	Paternal grandmother
Maternal grandfather	Paternal grandfather
Aunt(s)/ Uncle(s)	
Spouse/ Partner or Children	

FINANCIAL RESPONSIBILITY

I understand and agree that payment in full is required at each visit. I agree that I am responsible for payments for services my insurance carrier may determine non-covered, excluded, unreasonable or not medically necessary. I am responsible for charges incurred for all appointments, whether by phone, email or in-office. I understand my responsibility to pay includes fees for laboratory or other clinical services requested by Dr.Yoon. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Bay Natural Medicine and Dr. Yoon to take action to secure payment of an outstanding balance owed.

At your appointment you may pay with cash, check or Visa/Mastercard.
There will be a charge of $20.00 for all returned checks.

Cancellation of appointments:

- **If appointments are canceled with less than 24 hours notice, there will be a *$50 charge*.**
- **If appointments are canceled with more than 24 hours notice, *no charge* will be incurred.**

Missed appointments:

- **If the appointment was missed for any reason without notification, the *full amount* for the appointment will be due.**

At this time, Minna Yoon, ND, L.Ac. of Bay Natural Medicine does not participate in any insurance plans as an in-network provider. I understand that, if my health insurance plan or health savings account (HSA) provides reimbursement for services rendered by non-participating providers, I may

submit a claim myself to request reimbursement. I understand that it is my responsibility to know my plan benefits and that Bay Natural Medicine is not responsible for determining these benefits. If requested, Bay Natural Medicine will furnish me with a receipt to assist me to obtain reimbursement from my health insurance plan or HSA.

I understand that I may be offered a payment plan, by which I will pay according to an agreement set by me and Dr. Minna Yoon, ND, L.Ac. All outstanding charges must be paid within 6 months from the time of service.

I agree to the terms of the Financial Responsibility state above:

Signature: _____ Date: _____

INFORMED CONSENT

I, _____, hereby authorize Dr. Minna Yoon, ND, L.Ac. to perform procedures associated with Naturopathic and Chinese Medical services. This may include, but not limited to, nutrition and vitamin therapies, Western and Chinese herbal supplements, acupuncture, counseling, ordering laboratory tests and/or imaging, performing physical and/or gynecological exams, if necessary.

I understand that we may discuss treatments that have not been subject to double blind clinical studies or FDA approval or regulation. I assume the responsibility for the decision to take any natural therapies. Rare negative reactions to natural treatments may include allergic reactions, headaches, itching, hives, difficulty breathing, and very rarely, even shock or death. I understand that the interactions between drug-herb-nutrient interactions are not yet well known, and that while unlikely, I could have an adverse reaction. I could experience a reduction or increase in the effect of the medication I am taking. This can have serious consequences especially for some medications, such as for the control of blood pressure, blood sugar and blood clotting. To prevent confusion, I will always inform my doctors of all recent changes in treatments, procedures, medications, nutrition and supplements, particularly prior to surgery.

I have been informed of the potential risks involved with acupuncture, which may include but not limited to, discomfort, pain, infection, discoloration, burns, pneumothorax, dizziness or fainting, and aggravation of pre-existing symptoms.

I understand that Dr. Minna Yoon, ND, L.Ac. does not offer emergency medical services, after hour services or provide any hospital-based services. If I have a medical emergency, I will go immediately to the emergency room or call 911.

The potential benefits are 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 progress.

The principles of Naturopathic care is prevention, education, empowerment, individualized attention, emphasis to do no harm, and respect of the body's ability to heal itself. While I may experience some immediate improvement from initial appointments, I understand that the most effective results occur when I make a long term commitment to my health care.

I have read and understand the information provided. I agree to the services provided by Minna Yoon, ND, L.Ac.:

Signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____

Summary Notice of HIPPA Privacy Practices

The attached Notice describes how health information about you may be used and disclosed at Bay Natural Medicine and your rights regarding the use of that information. **Please review this summary and the full notice carefully.**

Bay Natural Medicine understands that information about you and your health is personal. We are committed to protecting your health information. Dr. Minna Yoon and staff must follow these rules.

You may have certain rights regarding your protected health information:

- Right to access your protected health information
- Right to amend your protected health information
- Right to accounting of disclosures
- Right to request restrictions on the use and disclosure of your protected health information
- Right to receive confidential communications
- Right to a paper copy of this notice
- Contact information for exercising your rights

Bay Natural Medicine may use and disclose your health information to improve your treatment.

- We may use and disclose your protected health information to assist your other health care providers in your diagnosis and treatment.
- See Page 1 in the "Notice of Privacy Practices" for more information. If you have concerns about how your health information might be (or has been) shared, please speak with Dr. Minna Yoon, N.D., L.Ac. directly at (415)564-3200.

If you believe your privacy rights have NOT been maintained while receiving services, you may file a complaint with Bay Natural Medicine or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Bay Natural Medicine, send the complaint to Dr. Minna Yoon, N.D., L.Ac. at 919 Irving St., Ste 104, San Francisco, CA 94122, or call (415) 564-3200. To file a complaint with the Secretary, the address us U.S. Dept. of Health and Human Services, Office of Civil Rights, Attn: Regional Manager, 50 United Nations Plaza, Rm. 322, San Francisco, CA 94103. You will not be penalized in any way for filing a complaint.

I acknowledged receipt of the Bay Natural Medicine "Notice of Privacy Practices." I understand that my signature does not authorize disclosure, but only acknowledges that I have read a copy of the full notice.

Signature: _____ **Date**: _____
Printed Name: _____ **Relation (if other than patient):** _____
Patient/Client declined to sign receipt (staff signature): _____
Patient/Client unable to sign (witness signature): _____
Reason unable: _____ **Interpreter**: _____