



**Dr. Sarah Skolout, ND**  
**(253) 237-0623**

**Patient Profile**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Yes, we may leave detailed messages on your  primary phone  other phone

E-mail: \_\_\_\_\_

How did you learn about our clinic? \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Information**

Primary Insurance Company: \_\_\_\_\_ Plan Name: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Birth date of Policy Holder: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Plan Name: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Birth date of Policy Holder: \_\_\_\_\_

**Authorization and Agreement of Payment**

I hereby authorize direct insurance payment to my physician for services rendered by Dr. Sarah Skolout. I understand that **I am responsible for knowing and understanding my insurance policy and benefits** and that I am responsible for any co-pays, deductibles or services not covered by my insurance. I also authorize release of any medical records that may be necessary for either medical care or processing of claims.

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Policies**  
**Dr. Sarah Skolout, ND**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Financial Responsibility:** Patients must arrive at their scheduled appointment with their insurance card and driver's license. Insurance copays required by a patient's insurance plan must be paid at time of the appointment. All fees for herbs and supplements must be paid at time of service. When you or your child is scheduled for a Well Patient Exam, it will be billed as such to your insurance plan. Insurance companies may refer to this as Preventative Care or Routine Exam. Due to coding laws, we MUST bill your Well Patient Exam as Preventative Care. If during your visit you have additional concerns or problems that require a diagnosis and/or other treatment, it may be considered a Problem Oriented Exam and you may incur additional office or lab charges. Additional services, such as manual therapy, exercise therapy, and spinal adjustments are billed separately and may not always be covered by your insurance plan. If your insurance company does not cover some or all of these charges, you will be billed directly for the balance. Naturopathic physicians are not covered by Medicare, Medicaid, medical coupons, or DSHS.

Please take the time to make yourself familiar with your insurance benefits. There are many plans and your benefits can change often. **It is YOUR responsibility to make sure that your specific policy covers NATUROPATHIC CARE and what your limits may be. We do not verify your benefits. The usual amounts billed to insurance for office visits are \$250 for initial visits and \$145 for return visits. Additional fees for labs, procedures, and supplements may apply. If your insurance does not cover your visit, you will be responsible for these fees.** Balances 90 days past due will incur a 5% per month late fee and may be subject to external collection action. Returned checks will incur a \$25 fee.

**Late cancelation and missed appointment fees:** We require 24 hours notice for all appointment changes. Missed appointments without proper notice will be charged a \$50 fee. If you are more than 15 minutes late for you appointment you will be asked to reschedule and be charged the \$50 fee. **Confirmation calls are a courtesy only.** You will still be charged a missed appointment fee if you did not receive a confirmation call.

**Phone Consults:** Existing patients may schedule phone consults. Consult fees are \$40 per 15 minutes. Please note that insurance companies will NOT pay for phone consultations.

**Informed Consent for Treatment:** I hereby authorize qualified medical personnel to perform routine and emergency medical procedures as necessary to facilitate my or my child's diagnosis and treatment. This includes the following: common diagnosis procedures, minor office procedures, physical medicine procedures, use of botanical, nutritional, and homeopathic medicine, and immunizations. I recognize there are potential risks and benefits of these procedures. This authorization will be in effect until revoked in writing by me.

**Notice for Women:** All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

Patient/Parent/Guardian Signature: _____	Date: _____
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**Notice of Privacy Practices  
Dr. Sarah Skolout, ND**

**Who will follow this notice**

- Dr. Sarah Skolout, ND and all associates and staff members.

**Our responsibilities**

- Dr. Sarah Skolout respects your privacy. We understand that your personal health information is very sensitive. We will not disclose information to others unless you tell us to do so, or unless the law allows us or requires us to do so.
- The law protects the privacy of the health information we create and obtain in providing care and services to you.

**How we may use and disclose medical information about you**

**For Treatment:** Information obtained by members of our healthcare team will be recorded in your medical record and used to help decide what care may be right for you. For example, your doctor may need to consult with specialists about your care.

**For Payment:** We will not disclose your health information to third party payers without your authorization unless allowed to do so by law. We may release medical information about you for worker's compensation or similar programs.

**Communication with family and friends:** We may release medical information about you to a family member or friend who is involved in your care and/or helps pay for your care. We will not disclose your information to other family members or friends without your authorization.

**Appointment Reminders:** We may contact you as a reminder that you have an appointment for treatment or medical care at our clinic.

**Research:** We may disclose information to researchers when an institutional review board has approved the research proposal and established protocols to ensure the privacy of your health information.

**As required by law:** We will disclose medical information about you when required to do so by federal, state, or local law.

**To avert a serious threat to health or safety:** We may disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. This may include disclosure to law enforcement officials, public health officials, national security, and intelligence agencies.

**Your Health Information Rights**

**Right to this notice:** You have a right to a paper copy of this notice. You may ask us to give you a copy at any time.

**Right to inspect and copy:** You have a right to inspect and receive a copy of certain health care information including certain medical and billing records. If you request a copy of this information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

**Right to request restriction:** You have the right to ask us to restrict certain uses and disclosures of your health information. We will comply with all reasonable requests.

**We reserve the right to change this notice at any time. Any revised or changed notice will be effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of our current notice in our clinic.**

Please contact us if you have any concerns. You may also contact the Secretary of the US Department of Health and Services.

Patient/Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Present Health Concerns** (please use the last page if you require more space)

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Current Medications	Dose	Prescribing Doctor	Reason for taking

Current Supplements, herbs, vitamins	Dose	Brand	Reason for taking

Height \_\_\_\_\_ Weight \_\_\_\_\_

Do you have allergies to any medications or anything else? Yes      No

If yes, please explain \_\_\_\_\_

**Past History with Dates of:** Hospitalizations, surgeries, serious illnesses or injuries: \_\_\_\_\_

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**List health care providers you currently see and their specialty (i.e. PCP, gynecologist, acupuncture)**

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Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Personal and Family History**

Please check the “yes” box next to each condition that applies to you or your family members. Indicate who has the condition (i.e. self, mother, etc.) and whether it is a current or past condition.

	Yes	Relation/Self	Past/Current		Yes	Relation/Self	Past/Current
Substance addiction				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema				Other			
Epilepsy							

Please circle any of the following substances that you use regularly: Tobacco      Coffee      Soda  
Alcohol      Recreational Drugs

Are you concerned you may have a problem with any of the above substances?      Yes      No

Do you follow a specific diet or have any dietary restrictions? \_\_\_\_\_

Do you exercise regularly? Yes      No      Average hours of sleep per day \_\_\_\_\_ Do you sleep well? \_\_\_\_\_

Occupation: \_\_\_\_\_

Current relationships: \_\_\_\_\_

Do you have any children? Yes      No      Ages: \_\_\_\_\_

**Additional Information**

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