ARIA INTEGRATIVE MEDICINE
3216 NE 45th Place, Suite 300
Seattle, WA 98105
Phone: (206) 588-1227
Fax: (206) 588-1387
www.AriaIntegrative.com
info@ariaintegrative.com

NEW PATIENT PACKET

Welcome to Aria Integrative Medicine!

We look forward to working with you to improve your health. Please read the following information carefully and complete the forms in this packet before your first visit. By filling out these forms ahead of time, you are helping us to serve you more efficiently.

The forms in this packet that should be completed and brought in at the time of your first visit include:

1. Patient Information Form
2. Consent for Treatment
3. Acknowledgement of Privacy Practices
4. Acknowledgement of Payment Policy
5. Authorization to Release Patient Health Information

In addition to the forms listed above, please fill out the *Health Information Form* on our website and submit it to our office **no later than 48 hours before your appointment**. If we do not receive this form ahead of time, your appointment will need to be rescheduled. This form can be emailed, sent by US post, faxed, or brought to our office.

Cancellation Policy:

If you need to cancel or reschedule your appointment, please contact us at least 24 hours before your scheduled appointment time or you may be charged a cancellation fee of up to $150.00 for your missed appointment.

Your health and your healthcare experience are of the utmost importance to us. Thank you for taking the time to complete this packet as accurately as you can.

We look forward to meeting you!

Sincerely,

Aria Integrative Medicine Team

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PATIENT INFORMATION FORM

Please Print

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: _____ First:_____ Middle: _____

Other name(s) that records may be kept under: _____

Date of Birth: _____ / _____ / _____ Gender: _____ (specify if needed)

Street address: _____ City: _____ State: _____ Zip: _____

Mailing Address (if different): _____ City: _____ State: _____ Zip: _____

Email 1: _____ ☐ Work ☐ Personal

Email 2: _____ ☐ Work ☐ Personal

Can we send confidential email's for you to any of the above email addresses? ☐ Email 1 ☐ Email 2 ☐ No

As a patient you are automatically added to our clinic email list to receive news and information. If you would not like to be on this list, and only contacted directly for patient related information, please check this box ☐

Phone 1: (_____) _____
☐ Work ☐ Home ☐ Cell

Phone 2: (_____) _____
☐ Work ☐ Home ☐ Cell

Can we leave confidential voicemail messages for you at any of the above numbers?: ☐ Work ☐ Home ☐ Cell

Marital Status (check one)
☐ Single/Never Married
☐ Married
☐ Divorced
☐ Separated/Not Divorced
☐ Widowed
☐ Domestic Partnership

Emergency Contact

Name: _____

Cell Phone: (_____) _____

Work Phone: (_____) _____

Relationship: _____

Are you currently Employed? ☐ Yes ☐ No Employer Name: _____

Employer Address: _____

GUARANTOR INFORMATION

This section must be completed if someone other than the patient is financially responsible for the patient's account

Last Name: _____ First Name: _____ Middle Initial: _____ Gender: _____

Phone: (_____) _____ Date of Birth (required): _____/_____/_____ SSN: _____-_____-_____

Mother's Name (minors only): _____ Father's Name (minors only):_____

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 on [insert page here]

X _____ _____
Guarantor's Signature (Required) Date

HOW DID YOU HEAR ABOUT US?

☐ Printed Ad ☐ Internet Search ☐ Yellow Pages ☐ News Story ☐ Event/Workshop ☐ Email Newsletter ☐ Friend/Family

☐ Medical Referral: _____ ☐ Other: _____

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I also authorize Aria Integrative Medicine to release any information required to process my claims.

Patient/Guardian signature: _____ *Date*: _____

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CONSENT FOR TREATMENT

Aria Integrative Medicine is an integrative medical clinic that includes a number of medical treatment modalities. Due to the diversity of modalities offered at Aria Integrative Medicine, your treatment may include any or all of the following general modalities: East Asian medicine (Acupuncture), Naturopathic Medicine, Physical Medicine, Homeopathy, Psychological Counseling and Nutritional Counseling. All of our physicians and East Asian medical practitioners are licensed in the State of Washington and have completed graduate level training and national board certification.

Physicians and practitioners at Aria Integrative Medicine may perform any of the following specific procedures as necessary to facilitate assessment of condition, diagnosis, treatment, or otherwise address health concerns:

1. **General Diagnostic Procedures:** including but not limited to venipuncture, pap smears, radiography, and blood and urine laboratory analysis, general physical exams, neurological and musculoskeletal assessments
2. **Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions**
3. **Herbs/Natural Medicines:** prescribing various therapeutic substance including plant, mineral and animal materials. Substances may be given in the form of teas, pills, powders, tinctures (may contain alcohol); topical creams, pastes, plasters, washes; suppositories or other forms. Homeopathic remedies, often highly diluted quantities of naturally occurring substances, may also be used.
4. **Dietary Advice and Therapeutic Nutrition:** includes the use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.
5. **Soft Tissue and Osseous Manipulation** includes the use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction, high-velocity low-amplitude adjustments, functional indirect manipulation, and craniosacral therapy.
6. **Electromagnetic and Thermal Therapies** includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy and infrared and ultraviolet therapies or moxa (warming or indirect burning of an acupuncture point and hydrotherapies)
7. **Acupuncture**: insertion of special sterilized needles or lancets at specific points on the body
8. **Topical Treatments and Prepping**: includes cupping – a technique using glass cups on the surface of the skin with usually a heat-created vacuum; and Gua Sha – rubbing on an area of the body with a blunt, round instrument.

Potential Risks: While not common, harm can occur from any therapy. Some examples can include but are not limited to: Pain, discomfort, blistering, discolorations, infection, or burns from topical procedures, heat or frictional therapies, electromagnetic and hydrotherapies; loss of consciousness or deep tissue injury from needle insertions or needle breakage; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms. In addition, the patient must inform the practitioner if the patient has a severe bleeding disorder or pacemaker prior to treatment.

Potential benefits: 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: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques (including labor stimulating acupuncture points) or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

By signing below, I, (or my authorized representative on my behalf) authorize Aria Integrative Medicine and their staff to conduct any of the methods, procedures and therapeutic approaches listed above. I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Aria Integrative Medicine or its practitioners and staff regarding cure or improvement of my condition. 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 me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

_____ _____

Patient's Name (PRINT) **Guardian/Personal Representative's Name (PRINT)**

_____ _____

Patient's Signature **Guardian/Personal Representative's Signature**

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Acknowledgement of Receipt of Notice of Privacy Practices

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Aria Integrative Medicine has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints, I may contact:

Dr. Jennifer Bennett
(206) 588-1227

I also understand that I am entitled to receive updates upon request if Aria Integrative Medicine amends or changes its Notice of Privacy Practices in a material way.

_____ _____
Signature Relationship to Patient (if signed by someone other than patient)

_____
Date

THIS SECTION IS TO BE COMPLETED BY ARIA INTEGRATIVE MEDICINE IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgement

[ ] Other (specify): _____

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ACKNOWLEDGEMENT OF PAYMENT POLICY

At Aria Integrative Medicine, we accept full payment for all charges at the time of your appointment. If you have insurance coverage and you wish to submit a bill to your insurance company to request reimbursement for services received at Aria Integrative Medicine, please check with reception at the time of your visit to receive the appropriate paperwork.

Payment forms that we accept include check, cash, debit, HSA, FSA, MasterCard, Visa, Discover and American Express. Checks or credit card payments that are denied for lack of funds will incur a fee of $25.00.

Return Policy for purchased dispensary items: All items purchased from the Aria Integrative Medicine dispensary must be paid for at the time of purchase. All items from the dispensary may be returned if *unopened* within 30 days of purchase if they are accompanied with a receipt of purchase, excluding items that are formulated in office or dispensed in bulk (homeopathics, tinctures, etc). Reimbursement for the price of the product can be given in a credit on the account or in the dollar amount of the product.

Please read the statements below carefully

I understand that I will be responsible for all charges whether or not they are covered by my insurance. I understand that payments for all services will be made in full at the time of service.

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 charges will begin accruing on accounts that are 60 days past due at a rate of 1.5% per month. I further understand that overdue accounts may be forwarded to an outside collection agency and I will be responsible for any fees generated from collection efforts.

I understand that the guarantor listed on my Patient Information Form is subject to the same financial terms as outlined above and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposed 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 hereby acknowledge that I agree to the policy above.

_____ _____

Name (Print) Date

_____

Signature of Patient or Guarantor