PSR_____

PSR _____

BASTYR UNIVERSITY

Patient Registration

PLEASE WRITE LEGIBLY

Patient Name:_____

Last Name First Name Middle Initial

What is your preferred first name? (Nickname, Chosen name, etc.) _____

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

DOB (required)_____SSN:_____

Address:_____

City:_____State:_____Zip Code: _____

Email address:_____

Phone: *Appointment reminders will be sent to 1st preference.*

1. □ Cell □ Home □ Work: (_____)_____ **Confidential voicemail OK?** ☐ Yes ☐ No

2. □ Cell □ Home □ Work: (_____)_____ **Confidential voicemail OK?** ☐ Yes ☐ No

---

The information you provide helps us to serve you and other members of the community and assists us to help you reach your health goals. Your answers are both voluntary and private.

What is your birth sex? □ Male □ Female □ Unknown □ Another: _____

What gender do you identify as? □ Male □ Female □ Trans □ Another: _____

What is your pronoun? □ He □ She □ They □ Another: _____

Primary Language:_____

Marital Status: □ Single □ Married □ Significant other □ Widowed

---

Primary Care Provider (PCP) Information (Please select one of the following):

☐ I wish to establish Primary Care with Bastyr.

☐ I see Bastyr for ancillary/adjunctive care only. My Primary Care Physician (PCP) is: _____

☐ If seeking adjunctive cancer support, who is your oncologist?_____

- Last physical: _____ Date of Last bloodwork: _____

☐ Other providers: _____

Guarantor – *If different from the patient* (Person who is financially responsible for the account)

Name:_____Relationship to the patient: _____

Address:_____

City:_____State:_____Zip:_____

Legal Guardian? □ Yes □ No SSN:_____ Gender: □ M □ F DOB:_____

CONTINUED ON BACK

Emergency Contact or Other Guardian/Parent Name: _____

Relationship:_____ Legal Guardian? □ Yes □ No

Primary Phone_____ Work Phone_____

Please provide your insurance information below:

Primary Insurance Company:_____ Group # _____

Member ID #_____ Relationship to Subscriber:_____

Claims Address: _____

Subscriber Name (if other than patient):_____ DOB: _____

Secondary Insurance Company:_____ Group # _____

Member ID #_____ Relationship to Subscriber:_____

Claims Address: _____

Subscriber Name (if otherthan patient):_____ DOB: _____

Check if applicable: □ Auto Accident □ Workers compensation Date of Accident:_____ Claim#:_____

****Please be prepared to present your insurance card at check-in at each visit****

Employment Status (Check one): □ Full Time □ Not Employed □ Part Time □ Retired □ Seasonal

□ Self-Employed □ Student (Full Time) □ Student (Part Time) □ Bastyr Student □ Bastyr Staff/Spouse

Employer_____

Address_____

How did you hear about us?

□ Friend/Family □ Event/Health Fair □ Shuttle/Bus □ Staff/Student □ Physician: _____

□ Radio/TV □ Walk/Drive By □ Social Media □ Yelp □ Other: _____

□ Advertisement – Digital (e.g. internet ad) □ Advertisement – Printed (e.g. magazine ad) □ Internet Search

□ Please sign me up for the Clinic newsletter so I can stay up to date regarding clinic hours, events anddiscounts.

Research is vital to the advancement of natural medicine.

□ Yes! Please contact me for future research participation. If Bastyr has a research study, I can helpwith:

I certify the above information is true and correct to the best of my knowledge. I acknowledge that I am the guarantor and financially responsible for payment of all services rendered, and that I am subject to all terms on the financial consent form.

_____ _____

Patient/Guardian Signature **Date**

Demographic Data Collection

Bastyr is committed to providing quality care for all patients. We are asking you to provide your racial and ethnic background and if you are/were military. This information enables us to learn more about the health needs of our community and better design our services to meet those needs. Your answers are both voluntary and private. Thank you for your cooperation.

1. Do you consider yourself Hispanic or Latino? Please check one.

- ☐ I AM Hispanic or Latino
- ☐ I am NOT Hispanic or Latino
- ☐ I don't know
- ☐ Decline to answer

2. Which category best describes your race? You may check one or more.

- ☐ Asian
- ☐ American Indian
- ☐ Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ White or Caucasian
- ☐ Other race
- ☐ I don't know
- ☐ Decline to answer

3. Active Military or Veteran

☐ Yes ☐ No

Patient initials _____

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BASTYR UNIVERSITY

PERSONAL HEALTH HISTORY for YOUR CLINICAL TEAM

Patient:_____ Date of Birth:_____

Last Name First Name Middle Initial

What is the main reason, or goal, for your visit today? _____

Allergies: Do you have a severe allergy to any of the following? (**Please select all that apply)**

☐ Sulfa	☐ Penicillin	☐ Aspirin	☐ Codeine	☐ Latex	☐ Sulfites
☐ Cats	☐ Dogs	☐ Mold	☐ Dust	☐ Bees	☐ Pollen
☐ Wheat	☐ Shellfish	☐ Peanuts	☐ Eggs	☐ Milk	☐ Soy

☐ Other _____

Medications: List all medications, over-the-counter medications, vitamins, or other supplements you are taking.
If you need additional space to list medications/supplements, please use page 6 or the back of page 7.

Name of Medication/Supplement	Dose	Frequency Taken

Medical Conditions: Do you currently have or have a history of the following? **(Please select all that apply)**

☐ Adrenal Disorder	☐ Depression	☐ Inflammatory Bowel Disease
☐ Anemia	☐ Diabetes Mellitus	☐ Irritable Bowel Syndrome
☐ Anxiety	☐ Digestive Problem	☐ Kidney Disease
☐ Arthritis/Joint Disorder	☐ Heart Disease	☐ Liver Disease
☐ Asthma	☐ Hyperlipidemia	☐ Stroke
☐ Cancer	☐ Hypertension	☐ Thyroid Disease
☐ COPD		☐ Other:

Surgeries / Hospitalizations: (Please select all that apply and write in date.)

- ☐ Appendectomy
- ☐ Brain Surgery
- ☐ Breast Surgery
- ☐ CABG
- ☐ Cholecystectomy
- ☐ Colon Surgery
- ☐ Cosmetic Surgery
- ☐ C-Section (If applicable)
- ☐ Eye Surgery
- ☐ Fracture Surgery
- ☐ Hernia Repair
- ☐ Hysterectomy (If applicable)
- ☐ Joint Replacement
- ☐ Prostate Surgery (If applicable)
- ☐ Small Intestine Surgery
- ☐ Spine Surgery
- ☐ Tonsillectomy
- ☐ Tubal Ligation (If applicable)
- ☐ Valve Replacement
- ☐ Vasectomy (If applicable)
- ☐ Other:

Family History: Do you have a family history of any of the following?
(**Please "check" the boxes that apply to you**)

	No Known Problems	Alcohol/Drug Abuse	Arthritis	Asthma	Cancer	Heart Problems	Depression	Diabetes	High Cholesterol	Hypertension	Kidney Disease	Mental Illness	Stroke	Vision Problems	Other
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandpa	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandpa	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Aunt	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Uncle	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Aunt	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Uncle	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

☐ Adopted ☐ Family History Unknown

Social History: Please answer the following questions regarding your social history:

Tobacco Use

Tobacco Use: ☐ Never Smoker ☐ Former Smoker ☐ Passive Smoke Exposure (Second Hand) ☐ Current Smoker ☐Other
Start Date:_____End Date:_____
Type of tobacco used: ☐ Cigarettes ☐ Cigars ☐ Pipe
Packs/Day:_____Years:_____
Smokeless Tobacco: ☐ Current User ☐ Former User ☐ Never Used ☐ Unknown
Types: ☐ Snuff ☐ Chew
Quit Date (if applicable):_____
If you are a current tobacco user: Are you ready to quit? ☐ Yes ☐ No

Do you drink alcohol?	☐ Yes	☐ No

If **yes**, how many of the following do you have per week?
Drinks/Week: Glasses of Wine_____Cans of Beer_____Shots of Liquor_____

Do you currently use any of the following recreational or street drugs? (Please select all that apply):

☐ E-Cigs/Vape	☐ Marijuana	☐ Opioids	☐ Heroin
☐ Methamphetamine	☐ Amphetamines	☐ PCP	☐ Ecstasy
☐ LSD	☐ Ketamine	☐ Mescaline	☐ Psilocybin
☐ Cocaine	☐ Crack	☐ Nitrous Oxide	☐ Solvent Inhalants
☐ Barbiturates	☐ Benzodiazepines	☐ IV	☐ Other

If yes to Marijuana: □ Medicinal? □ Recreational? □ Both?
If yes to any of the drugs above how many times per week estimate do you use them? _____

What is your current birth control method? (Please select all that apply):

Sexually Active: ☐ Yes ☐ No

Birth Control/Protection:

☐ Abstinence	☐ Cervical Cap	☐ Condom	☐ Hormonal Patch
☐ Implant	☐ Injection	☐ Inserts	☐ Spermicide
☐ IUD	☐ Pill	☐ Rhythm	☐ Withdrawal
☐ Sponge	☐ Surgical	☐ Vaginal Ring	☐ Other
☐ Vasectomy	☐ Menopause	☐ None	☐ _____

Partners? ☐ Male ☐ Female ☐ Both ☐ Another

Sexual Orientation/Gender Identity (this helps our clinicians give you the best care possible)**:**

What is your birth sex?	☐ Male	☐ Female	☐ Unknown	☐ Another
What gender do you identify as?	☐ Male	☐ Female	☐ Trans	☐ Another
What is your pronoun?	☐ He	☐ She	☐ They	☐ Another

Do you have any children? ☐ Yes ☐ No If so, what are their ages:

Do you exercise regularly? ☐ Yes ☐ No If so, how often and what type of exercise?

Do you have any dietary restrictions or food intolerances? ☐ Yes ☐ No If so, what?

Additional Medications/Supplements?

Name of Medication/Supplement	Dose	Frequency Taken

CONTINUED ON NEXT PAGE

Review of Systems: Please check if you have experienced any of the following in the last 3 months.

Constitution		
☐ Activity change	☐ Sweating	☐ Unexpected weight change
☐ Appetite change	☐ Fatigue	☐ Fever/Chills
Head, Ears, Neck, and Throat		
☐ Congestion	☐ Hearing loss	☐ Sneezing
☐ Dental problem	☐ Mouth sores	☐ Sore throat
☐ Drooling	☐ Nosebleeds	☐ Ringing in your ears
☐ Ear discharge	☐ Postnasal drip	☐ Trouble Swallowing
☐ Ear pain	☐ Runny nose	☐ Voice change
☐ Facial swelling	☐ Sinus pressure	
Eyes		
☐ Eye discharge	☐ Eye pain	☐ Sensitivity to light
☐ Eye twitching	☐ Eye redness	☐ Visual disturbance
Respiratory		
☐ Snoring	☐ Cough	☐ Wheezing
☐ Chest tightness	☐ Shortness of breath	
Cardio		
☐ Chest pain	☐ Leg Swelling	☐ Palpitations/Irregular heartbeat
Gastrointestinal		
☐ Abdominal bloating/distension	☐ Blood in stool	☐ Nausea
☐ Abdominal pain	☐ Constipation	☐ Vomiting
Endocrine		
☐ Cold intolerance/sensitivity	☐ Excessive thirst	☐ Large volume/amount of urine
☐ Heat intolerance/sensitivity	☐ Excessive hunger	
Genitourinary		
☐ Difficult/painful urination	☐ Increase/urgency in urination	Female patients:
☐ Pain with sex	☐ Genital sore	☐ Menstrual problems
☐ Urine incontinence/leakage	☐ Blood in urine	☐ Vaginal bleeding
☐ Pain in your side	☐ Pelvic Pain	☐ Vaginal discharge
Musculoskeletal		
☐ Painful joints	☐ Joint swelling	☐ Neck pain/stiffness
Skin		
☐ Color change	☐ Rash or Wound	☐ Pale appearance
Neurological		
☐ Dizziness/Light-headedness	☐ Numbness/Weakness	☐ Tremors
☐ Facial asymmetry Headaches	☐ Fainting	☐ Seizures
	☐ Speech difficulty	
Hematologic		
☐ Swollen lymph nodes	☐ Easily bruising or bleeding	
Psychiatric		
☐ Agitation	☐ Feeling of unease	☐ Self-injury
☐ Behavior problem	☐ Hallucinations	☐ Sleep disturbance
☐ Confusion	☐ Hyperactive	☐ Suicidal ideas
☐ Decreased concentration	☐ Nervous/anxious	

Global Health

Please respond to each question or statement by marking one box per row.

		Excellent	Very good	Good	Fair	Poor
Global01	In general, would you say your health is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global02	In general, would you say your quality of life is:.....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global03	In general, how would you rate your physical health?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global04	In general, how would you rate your mental health, including your mood and your ability to think?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global05	In general, how would you rate your satisfaction with your social activities and relationships?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global09r	In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.).....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
			Mostly	**Moderatel**	**A little**	**Not at all**
Global06	To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

In the past 7 days…

		Never	Rarely	Sometimes	Often	Always
Global 10r	How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

		None	Mild	Moderate	Severe	Very severe
Global 08r	How would you rate your fatigue on average?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Global	How would you rate your pain on average?	☐ 0 **No pain**	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 **Worst pain imaginable**

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CONSENT FOR TREATMENT

***General Information*:** The Bastyr Center for Natural Health (BCNH) and Bastyr University Clinic (BUC) are teaching facilities and have practitioners who do private practice also. Our teaching clinics have students studying at Bastyr University and integrate a number of medical treatment modalities. Our teaching clinics at BCNH and BUC use a 'Team Care' approach where faculty supervisors and student clinicians work as a team to address your health concerns. Student clinicians, depending on their levels of experience, may observe or participate in the care provided but are always supervised by healthcare providers licensed in the State of Washington or State of California. Your medical history, treatment plan and progress is discussed (without identifying information) among other student clinicians for educational purposes at the clinic and evaluated by the supervising faculty for appropriateness and effectiveness. Due to the diversity of modalities offered at BCNH or BUC, your treatment may include any or all of the following general modalities: East Asian Medicine, Naturopathic Medicine, Physical Medicine, Homeopathy, Psychological Counseling and Nutritional Counseling. Some modalities may be used exclusively on some specialty shifts, but many Bastyr clinic teams use multiple treatment modalities. All of our East Asian medical practitioner faculty are licensed in the State of Washington having completed graduate level training and national board certification.

Methods, Procedures and Therapeutic Approaches: Clinicians may perform general diagnostic procedures, psychological counseling, lifestyle counseling, exercise prescriptions, acupuncture, ayurvedic services, topical treatments, herbal medicine, natural medicine, dietary advice and therapeutic nutritional counseling, soft tissue and osseous manipulation, electromagnetic and thermal therapies.

Cancer or Malignancy: I understand that Washington State Law and California State Law does not authorize naturopaths or acupuncturists to treat me for any **cancer or malignancy** and that I am required to be under the care of a medical doctor or osteopathic physician (oncologist) while receiving care at Bastyr.

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 BCNH or BUC or any of its personnel regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. **I hereby acknowledge that I am financially responsible for services rendered.**

At Bastyr Center for Natural Health and Bastyr University Clinic, the safety and well-being of all of our patients and staff is our primary concern. Please know, we aim to have respectful conversations with all of our patients and in return we expect the same.

TELEMEDICINE WAIVER

I hereby consent to engaging in telemedicine with a Bastyr provider (current or future visit). I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine involves the communication of my medical information, both orally and visually, to my health care practitioners. The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand the information disclosed by me during the course of my treatment is confidential.

By signing this consent, I agree to proceed with a telemedicine visit and certify I am physically in the state of Washington if my Provider is from Bastyr Center for Natural Health in Seattle or California if my provider is from Bastyr University Clinic in San Diego. If I will not be in the state when the appointment will take place, I understand it is my responsibility as the patient to reschedule my appointment.

In addition, I understand telemedicine-based services and care may not be as complete as face-to-face services. I understand if my Provider believes another form of medical services (e.g. face-to-face services) would better serve me, I will be asked to schedule an in office visit with my provider or referred to a medical services provider who can provide such services if applicable. Finally, I understand there are potential risks and benefits associated with any form of medical treatment, and despite the efforts of the provider, my condition may not be improved or my provider may recommend.additional care. I understand I may benefit from telemedicine and understand results cannot be guaranteed or assured.

I have no other pre-existing conditions that have not already been disclosed to my provider. I understand this visit/encounter does not and should not replace a traditional doctor's office visit; therefore, I am proceeding with this tele-evaluation at my own risk and understanding. I understand that should my condition worsen I should contact local emergency response by dialing 911. I certify the information provided to my provider is true and accurate to the best of my ability. I understand that omitting medical information or misinforming a Bastyr provider may result in an inaccurate diagnosis and treatment.

FINANCIAL AGREEMENT

What you should know:
By signing this agreement you have agreed to pay for your services either by self-pay or using insurance benefits that cover the services you receive. If you don't have insurance we have many discounted contracts you may qualify for; please ask us.

Health insurance is a contract between you and your insurance company. It's best if you know which services your insurance will cover before you receive care. That way, there are no surprises for either of us. If you are not sure about your coverage, please ask your insurance company. Refer to the back of your insurance card.

Nonpayment
If you have not paid your bills within 30 days after receiving your final notice you will be turned over to collection agency, Professional Credit Services. You will be responsible for any collection agency fees that apply. If you have large unpaid balances and make no arrangement or payments you may be reported to a credit bureau and denied additional services at Bastyr. If this happens we can help you transfer your care.

Insurance billing
- Contract coverage: Bastyr contracts with many insurance plans. If we are in your health plan's network, you are expected to pay any cost shares at the time of service
- Non-contracted: If your insurance plan is not contracted with Bastyr we will bill your insurance as a courtesy to you. You are responsible for the full cost of care. If your insurance does not pay within 45 days, the balance will be billed to you.

Care or services not covered by your insurance plan

Bastyr has many services that are non-covered by insurance plans. Some services might be considered experimental for research purposes only by your insurance company. If that is the case, you will be responsible for the full cost. We expect payment at the time of the service.

Returned Checks

Bastyr charges $28.00 for any returned checks.

Questions? Please contact our Billing Office at 206-834-4183, if you have any questions about anything in our policy.

PATIENT CANCELLATION AND NO SHOW AGREEMENT

To provide you with high-quality care, it is important for you to keep your scheduled appointment with the medical provider. Valuable time has been reserved for you or your family member. A missed appointment or late cancellation results in lost time that could have been given to another person wanting to receive care.

- Patients arriving more than 15 minutes late to their appointment will be subject to the providers' discretion as to whether they can be seen. Late arrivals may also be subject to an abbreviated visit.
- If a patient cannot be seen, or is more than 20 minutes late for a scheduled visit, it will automatically be considered a no show.

You will receive a reminder call/text two days ahead to remind you of your appointment; however, it is your responsibility to keep record of your appointment and to arrive on time. If you need to cancel or reschedule your appointment, please call 24 hours in advance. You may also leave a message with our scheduling desk. Every late cancel/no-show will be recorded in your chart. Multiple late cancels and no-shows can end your ability to make advance appointments or receive care at Bastyr Center.

We realize that an emergency may occur and/or you may not be able to notify us. We will discuss that situation with you when it happens.

- **After One (1) Late Cancel/No Show: You will be reminded of our Late Cancel/No Show policy.**
- **After Two (2) Late Cancels/No Shows: There will be a charge of $40 for appointments in Team Care, or $60 for appointments in Practitioner Care. (Bastyr Students will be charged $30.)**
- **After Three (3) Late Cancels/No Shows: Advanced scheduling privileges will be suspended for three months. You can still be seen on a same-day scheduling basis only, depending on provider availability. We cannot guarantee that you will be seen.**

Thank you for working with us to ensure that services are provided to all our patients in the best possible way.

NOTICE OF PRIVACY PRACTICES

Acknowledgement

Bastyr is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement, if possible, that you have received it. A parent or guardian should sign for patient under age 18. If you have questions concerning the management of your healthcare information at our clinic, or if you wish schedule an appointment to view your medical record, please call our medical records office at (206) 834-4151.

By signing this, I acknowledge I have reviewed the above Consent for In-Person and/or Telemedicine Treatment, Financial Agreement, Cancellation and No-Show Agreement, and acknowledge that I have been offered a copy of the Notice of Privacy Practices (available on our website or in person at the Clinics).

X _____ _____

REQUIRED: Print Name **Date**

X _____ _____

REQUIRED: Signature of Patient or Legal Guardian or Representative **Date**

_____

Relationship to Patient (if applicable)

Electronic consent and notice use only - By entering the above fields with your name, you are signing this document electronically. You agree your electronic signature is the legal equivalent of your manual signature on this document. By entering the above fields with your name, you consent to be legally bound by this documents terms and conditions. You further agree that your use of a key pad, mouse or other device to select an item, button, icon or similar act/action constitutes your signature (hereafter referred to as "E-Signature"), acceptance and agreement as if actually signed by you in writing.

Upon completion email form(s) to: patientcontact@bastyr.edu

PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD(S) AND ID / DRIVERS LICENSE