Seattle Integrative Medicine

New Patient Instructions

Please bring with you at the time of the visit:

- Your completed forms
- Your insurance card
- A list of supplements you are **currently** taking
- **Copies** of lab, pathology and diagnostic reports from last year **UNLESS** you have been diagnosed with Cancer, Hepatitis C or HIV in which case these copies are needed from the date of **first diagnosis** of these illnesses.

It is not necessary to bring copies of progress or chart notes.

Our time, like your own, is valuable and we require a **minimum of 24 hours notice to cancel or reschedule an appointment.** If this requirement is not met, you will be billed for the standard cancellation fee of $50.00.

If you have any further questions, do not hesitate to call us at (206) 525-8012. The clinic is open from 9am to 5pm Monday through Friday.

We look forward to meeting you!

Directions to Seattle Integrative Medicine

The clinic is located at 5322 Roosevelt Way NE between NE 55th and NE 52nd streets. Roosevelt Way is a one-way southbound street and therefore, when traveling by car, must be accessed at NE 55th street or further north. Roosevelt is parallel to and between I-5 and University Way, the major North-South thoroughfares in the University District.

From the South:
Take I-5 North and exit and NE 50th St (University of Washington exit)
Turn RIGHT at 50th. Travel eastward (toward the University) 3 blocks to 11th Ave NE
Turn LEFT on 11th Ave NE. Go north 2 blocks up 11th
Turn LEFT on NE 55th St. Go one block
Turn LEFT on Roosevelt. Go 1/4 block south to 5322 Roosevelt, a small tan house on the left side of the street with a wheelchair ramp out front.

From the North:
Take I-5 south and exit NE 50th St (University of Washington exit)
Turn LEFT at 50th. Travel eastward (toward the University) 4 blocks to 11th Ave NE
Turn LEFT on 11th Ave NE. Go north 2 blocks up 11th
Turn LEFT on NE 55th St. Go one block
Turn LEFT on Roosevelt. Go 1/4 block south to 5322 Roosevelt, a small tan house on the left side of the street with a wheelchair ramp out front

Look for street parking on Roosevelt, NE 55th St and 11th Ave NE. THERE IS NO CLINIC PARKING LOT AVAILABLE.

Seattle Integrative Medicine

Patient Registration

Please fill out completely

Patient Name:_____ MI:_____ Last:_____
Street Address:_____
City:_____ State:_____ Zip:_____
SSN:_____ Gender: ☐M ☐F Home Phone: (___)_____
Employer:_____ Work Phone: (___)_____
Date of Birth: _____/_____/_____ Age: _____ Alt Phone: (___)_____
Employment: ☐ Employed ☐ F/T Student ☐ P/T Student ☐ Retired ☐ Other
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Partnered ☐ Other
Referred By:_____
In Case of Emergency Contact: _____ Relationship: _____
Emergency Contact Phone Number: (___)_____

Primary Insurance

Insurance Company Name: _____ Phone: (___)_____
Claims Address: _____ City: _____ ST: ____ ZIP:_____
Subscribers Name: _____Date of Birth: ____/_____/_____
Relationship to you: _____☐Self ☐Spouse ☐Dependent ☐Other
ID/ Claim # (as shown on card):_____ Policy/Group #: _____
Employer of Insured: _____

Secondary Insurance

Insurance Company Name: _____ Phone: (___)_____
Claims Address: _____ City: _____ ST: ____ ZIP:_____
Subscribers Name: _____Date of Birth: ___/_____/_____
Relationship to you: _____☐Self ☐ Spouse ☐Dependent ☐ Other
ID/ Claim # (as shown on card):_____ Policy/Group #: _____
Employer if Applicable: _____ Effective Injury Date: _____

I understand that I am financially responsible for all charges and agree to pay for services. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Signature _____ Date _____

Seattle Integrative Medicine
5322 Roosevelt Way NE Seattle, WA 98105
Phone: 206-525-8012 Fax: 206-525-8013

Name: _____DOB:_____
Allergies (medication, food, etc.):_____
_____
Person to Contact in Case of an emergency:_____
Phone #: _____
Insurance Carrier: _____
Who referred you?: _____

History of Main Concern

Please describe how and when your main concern started, how it has progressed over time, and how it is affecting your life.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list all other practitioners you are seeing, their specialties and phone Numbers. (Note: they will not be contacted without your permission)

_____
_____
_____
_____

Past and Present Medical Diagnoses

_____
_____
_____
_____

Current Medications and Dosage

_____
_____
_____
_____
_____
_____

Current Nutritional Supplements and Dosage

_____
_____
_____
_____
_____

Health History

Patient Name:	DOB:	Date:

Family History: fill in health information about your family

Relation	Age	State of Health	Age of Death	Cause of Death	Check if your blood relatives have had any of the following	
					Disease	Relationship to You
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
					High Blood Pressure	
Sisters					Kidney Disease	
					Obesity	
					Tuberculosis	
					Vascular Disease	

Hospitalizations:		**Serious Illness/ Injuries**
Year	**Hospital**	
		Pregnancy History
Health Habits: Check which substance you use and describe how much you use them		**Allergies: To Medications or Substances**
☐	**Caffeine :** -	
☐	**Tobacco:** -	
☐	**Alcohol:** -	
☐	**Drugs:** -	
☐	**Other:**	
Pharmacy Name and Phone:		

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omission that I may have made in the completion of this form.

Signature:_____ **Date:** _____

Consent for Treatment

General Information: Seattle Integrative Medicine is an integrative care clinic comprised of physicians and practitioners skilled in a wide variety of health promoting treatments and procedures. Some of the services here include: naturopathic medicine including nutrition, botanical medicine, homeopathic medicine, physical medicine, psychological counseling, and lifestyle counseling; acupuncture; and conventional, drug-based medicine.

Methods, Procedures, and Therapeutic Approaches Which May Be Utilized:

- General Diagnostic Procedures**:** Include, but are not limited to, venipuncture, pap smears, radiography, blood/urine laboratory work, validated diagnostic questionnaires, physical examination including musculoskeletal and neurological assessments
- Psychological Counseling, Lifestyle Counseling, Exercise Prescriptions
- Acupuncture (insertion of special sterile needles at specific points on the body)
- Topical Treatments and Prepping (includes cupping- a technique using glass cups on the surface of the skin usually with a heat-created vacuum)
- Herbs/Natural Medicine: Prescribing of various therapeutic substances using plants, minerals, and animal materials. Substances may be teas, pills, powders, tinctures (may contain alcohol), topical creams, pastes, plaster washes, suppositories, or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substances, may be used
- Intravenous (IV) Rehydration/Nutrition: Use of essential and conditionally essential nutrients, including but not limited to vitamin C, magnesium, B vitamins, and calcium, diluted in saline and administered into a vein
- Dietary Advice and Therapeutic Nutrition: Use of foods, diet plans or nutritional supplements for treatment- may include intramuscular vitamin injections
- Soft Tissue and Osseous Manipulation: Use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy
- Electromagnetic and Thermal Therapies: Includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, infrared and ultraviolet therapies, moxa (warming of acupuncture points) and/or hydrotherapies.

Potential Risks*: Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies, allergic reactions to prescribed herbs or supplements, soft tissue or bone injury from physical manipulations, and aggravation of pre-existing symptoms.*

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 doctor if they know or suspect pregnancy as some of the therapies used could present a risk to the pregnancy.*

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 there are no guarantees given to me by the Seattle Integrative Medicine 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. This record will be kept confidential and will not be released to others unless so directed by me or otherwise permitted or required by law.

_____	_____
Patient Name (PRINT)	Guardian/Personal Representative's Name
_____	_____
Patient's Signature	Guardian/Personal Rep.'s Signature
_____	_____
Date	Relationship/Representative's Authority

Patient Responsibility and Confidentiality

Your Insurance Does Not Always Pay for Everything

It is the responsibility of the patient to determine whether services rendered at this clinic are covered by your particular insurance plan. Individual plans, even within the same company, vary tremendously. Every effort is made by our staff to be respectful of your financial limitations and to assist you. (i.e. your plan may specify you pay 20% of services.)

The practitioners at Seattle Integrative Medicine are committed to practicing the best medicine available, which sometimes includes therapies, labs, etc. not covered by your insurance. Every effort is made to obtain your consent prior to incurring such charges.

I accept financial responsibility for services rendered in this clinic:

_____ _____
Signature Date

Permission to leave voice mail on your answering machine?

We respect your privacy, yet there are times important information may need to be relayed to you via phone. In some cases, your standard contact numbers are not appropriate for this type of information.

Do you have a phone number where we can leave private information, such as lab results?

_____ _____ _____
Phone Signature Date

Permission to use your information for research purposes?

We are committed to the advancement of medicine. While our therapies are science-based, not all have been evaluated in clinical trials. Our therapies are sometimes experimental and the best way to evaluate their efficacy is to pool patient data/ results for research purposes. To use your data is such a fashion requires your signature. Your confidentiality is protected at all times and under no circumstances is your name attached to any of the data used for research purposes. Please sign below if we may use information from your chart for research purposes. You may retract this permission at anytime by stating this in writing.

_____ _____
Signature Date

Seattle Integrative Medicine

The independent practices of:

Marco Vespignani, ND
Laurie Mischley, ND
Samantha Evans, ND
Melissa McCarty, ND
Christian Dodge, ND

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the notice of privacy practices to read. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changed at any time. I may obtain a copy of the notice by calling 206-525-8012 or by requesting one at the office.

Date: _____
Signature:_____
Print your name here:_____

As a representative of the above individual, I acknowledge receipt of the notice on his/her behalf.

Date: _____
Signature:_____
Print your name here:_____
Relationship to Patient:_____