

OLYMPIA FAMILY HEALTH

A Naturopathic Family Practice

Robin E. Moore, ND

3773 C Martin Way East, Suite 102 Olympia, WA 98506

Phone: (360) 459-9082

Fax: (360) 459-4262

Scope of Practice

Olympia Family Health is a general practice in which people of all ages are treated. Physical exams, including sports physicals, and well child exams are given.

Naturopathy

Naturopathic medicine uses therapies derived from nature with the aim of activating the inherent healing powers of the human body. But naturopathy is about more than the body—as a naturopathic physician, I consider the whole person and the effects on health of the interaction of physical, mental, emotional, and spiritual aspects. Naturopathy also acknowledges that health is not a ‘spectator sport’ where someone else “fixes what’s wrong.” Health requires full participation.

A Focus on Health, Not Disease

The Latin word *doctoro*, from which we have *doctor*, means “to teach,” and teaching is an important part of being a naturopathic doctor. This means attending to the underlying causes of disease as well as addressing symptoms when they appear. Integral parts of my practice are teaching my patients how to be well. And diagnosing symptoms early which are when they respond best to treatment.

Insurance

Naturopathic physicians are licensed physicians in the state of Washington and, as such, are covered by many medical insurance companies. Call your company to find out whether your policy includes such coverage.

Education

Naturopathic medicine schools involve four years of professional training for which pre-med studies are required. The training involves two years of basic sciences followed by two years of clinical sciences. The last two years also include a large amount of clinical training in the schools’ outpatient clinics. There are optional internships available for new graduates.

John Bastyr College of Naturopathic Medicine
(Now Bastyr University)
14500 Juanita Drive NE Kenmore, WA 98028
(425)602-3075

Problem Areas Treated Include:

- **Cardiovascular:** such as heart arrhythmias, high blood pressure
- **Psychological and neurological:** such as pinched nerves, headaches, depression
- **Orthopedic:** such as musculoskeletal imbalances, osteoporosis, sprains
- **Respiratory:** such as colds, bronchitis
- **Ear, nose, and throat (ENT):** such as sore throats, ear infections, chronic congestion
- **Gastrointestinal:** colitis, ulcers, food allergies, constipation
- **Urinary:** bladder and kidney infections
- **Gynecological:** vaginitis, cervical erosion, ovarian cysts
- **Dermatological:** acne, allergic and infectious skin rashes, eczema, psoriasis

Thorough Diagnosis

Body systems interact in complex ways. I use the following tools and techniques to make a careful and thorough diagnosis:

- Getting to know your health history, not simply asking the standard questions
- Reviewing your medical records in detail and depth
- Making a direct examination to assess your health today
- Asking about and analyzing your diet
- Ordering laboratory tests if needed
- Having x-rays, scans, etc. taken if indicated

I routinely use the following lab tests and personally review and interpret the results:

- Blood counts and blood chemistry panels
- Routine preventative blood screenings and pap smears
- Urine analysis for heavy metals
- Digestive function tests
- Genetic testing for factors affecting cardiac, bone, immunity, and detox functions

I use only laboratories whose procedures and technologies I have full confidence in for the test being processed. All testing is confidential and genetic tests are processed anonymously.

Naturopathic Therapies

Naturopathic doctors receive training and experience in a wide range of healing methods, and I often use several together for the maximum benefit of each. Although this is not a full list of my areas of expertise, I most commonly use the following therapies:

- Adjustments to diet, including meal consumption and timing
- Nutritional supplements
- Homeopathic remedies
- Medicinal herbs
- Acupressure allergy desensitizing
- Physiotherapy such as ultrasound, diathermy and hydrotherapy
- Structural massage and spinal manipulation
- Exercise plans
- Counseling

Naturopathic treatment can work in conjunction with conventional medicine. I make a timely and well-directed referral when another health practitioner in our community can better serve your needs in a particular area. Your health is what is most important.

Today's Date: _____
Name: _____
Date of Birth: _____ Age: _____
Address: _____
Phone: (c) _____ (h) _____
Height: _____ Weight: _____
Number of Children: _____

OLYMPIA FAMILY HEALTH, INC.
ROBIN E. MOORE, N.D.
3773C MARTIN WAY E, SUITE 102
OYLMPIA, WA 98506

Occupation: _____
Insurance Co. _____
Policy #: _____
Preferred Pharmacy: _____

What health issues do you want help with? _____

What other health care are you presently receiving? _____

Who is your Primary Care Provider? _____

Medication Allergies: _____

Other Allergies (airborne, chemical, food): _____

List all operations, serious injuries or illnesses, including dates/age:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Medical History and Review of Systems:

Circle the H for "History" if you have had that problem in the past

Circle the C for "Current" if you have that problem now.

H C Frequent urination	H C Sexual function problems
H C Incontinence	H C Low sex drive
H C Kidney stones	H C Painful Intercourse
H C Getting up more than once at night to urinate	H C Erectile Dysfunction
H C Prostate issue (BPH, cancer, prostatitis)	

H C Joint pain	H C Broken bone(s)
H C Joint stiffness / swelling	H C Back pain
H C Scoliosis	H C Muscle cramps
H C Osteoporosis	H C Overly flexible joints
H C Autoimmune Arthritis (RA, Lupus)	

H C Headaches	H C Poor concentration / easily distracted
H C Migraines	H C Memory changes
H C Depression	H C Abnormal sensation (numbness, tingly, pain)
H C Anxiety	H C Chronic pain
H C TIA or Stroke	H C Concussion
H C Tremors	H C Dizziness / poor balance
H C Seizures	H C Chronic neurological condition:

H C Acne	H C Dry skin
H C Eczema	H C Skin rashes
H C Wounds heal slowly	H C Skin cancer
H C Tongue abnormalities	H C Psoriasis

H C Fibromyalgia
H C Fatigue
H C Poor immunity
H C Decreased appetite
H C Poorly controlled appetite
H C Overweight
H C Insomnia
H C Diabetes or pre-diabetes

H C Low thyroid
H C Fainting
H C Genetic abnormality
H C Bleed or bruise easily
H C Cancer
H C Weight loss
H C Gain weight easily
H C Addictions (drugs, alcohol, nicotine)

H C Headache
H C Migraines
H C Hearing difficulty
H C Chronic ear infections
H C Visual disturbances
H C Perceptual problems (eg. dyslexia)
H C Poor night vision

H C Sinus problems
H C Nasal congestion
H C Dental trouble
H C Receding gums
H C Nose bleeds
H C Cataracts
H C Glaucoma

H C Chronic cough
H C High cholesterol
H C Rheumatic fever
H C Heart palpitations
H C Irregular heartbeat
H C Tuberculosis
H C High blood pressure
H C Low blood pressure
H C Stroke

H C Shortness of breath
H C Chest tightness or pain
H C Heart murmur
H C Ankle swelling
H C COPD
H C Sleep propped up with pillows
H C Asthma
H C Heart attack or artery disease

H C Difficulty swallowing
H C Excessive burping
H C Heartburn / GERD
H C Nausea
H C Vomiting
H C Hiatal hernia
H C Ulcer
H C Colitis / Crohn's
H C Diverticulitis

H C Abdominal pain
H C Gallstones
H C Excessive abdominal gas—chronic
H C Constipation
H C Hemorrhoids
H C Loose stools / diarrhea
H C Black stools
H C Blood in stools

Women Only:

H C Premenstrual problems
H C Irregular menstruation
H C Painful menstruation
H C Heavy periods
H C Menopausal symptoms
H C Abnormal Pap

H C Spotting between periods
H C Vaginal infections
H C Breast lumps
H C Abnormal discharge
H C Endometriosis

Age at first period: _____

Date of last period: _____

Date of last pap smear: _____

Age at menopause: _____

How many days is your average menstrual flow? _____

How many days long is your entire cycle? (Start at day 1 of period until day 1 of next cycle) _____

Family History

Do any of your relatives have the following health problems? If so, please list their relation to you. Then, check once for each relative with that problem.

Example: ☒ ☒ Asthma son, uncle

☐ Addiction (drugs, meds, etc) _____	☐ High blood pressure _____
☐ Alcohol abuse _____	☐ Kidney problems _____
☐ Allergies _____	☐ Liver problems _____
☐ Arthritis _____	☐ Lung problems _____
☐ Asthma _____	☐ Migraines _____
☐ Cancer _____	☐ Overweight _____
☐ Gastro-intestinal problems _____	☐ Prostate problems _____
☐ Depression/anxiety _____	☐ Psoriasis _____
☐ Eczema _____	☐ Stroke _____
☐ Gynecological problems _____	☐ Suicide _____
☐ Gallstones _____	☐ Ulcer _____
☐ Heart problems _____	☐ Other: _____

In terms of birth order, what number child are you? _____

_____ No. of brothers _____ No. of sisters

Habits

Exercise (type, frequency, duration) _____

Sleep—Hours needed: _____ Hours gotten: _____

Bowel movements per day: _____

How many hours can you go without eating and still feel good? _____

What do you do for fun? _____

Alcohol (Type, frequency, amount) _____

Do you use other recreational drugs? _____

Do you smoke cigarettes? _____ How many? _____ per day. How many years? _____ Vape? _____

What are your main stress factors? _____

How much do you think these stresses are affecting you? _____

MEDICATIONS

What medications are you taking now? Include non-Rx'd preparations.

[illegible]

VITAMINS, MINERALS & NUTRITIONAL SUPPLEMENTS

List all vitamins, minerals and other nutritional supplements.

Indicate strength in mg or IU's, and the form (calcium carbonate vs calcium lactate) when possible.

[illegible]

* Please bring the labelled bottle, or the label only, of any multi-vitamin or vitamin/mineral or combination nutritional supplement you are taking.

APNEA SCREENING QUESTIONNAIRE

This questionnaire helps to determine your risk for having sleep apnea.

TODAY'S DATE: _____	HEIGHT: _____
PATIENT NAME: _____	WEIGHT: _____
DATE OF BIRTH: _____	BMI: _____

	YES	NO	NOT SURE
1. Have you ever had a sleep study? If so, When? _____	☐	☐	☐
2. Were you diagnosed with Obstructive Sleep Apnea?	☐	☐	☐
3. Are you currently using a CPAP device?	☐	☐	☐

SYMPTOMS: Please check all that apply, each YES answer equals 1 point.

4. Do you <u>SNORE</u> loudly?	☐ (1pt)	☐	☐
5. Are you <u>TIRED</u> , fatigued or sleepy on most days?	☐ (1pt)	☐	☐
6. Has anyone <u>OBSERVED</u> you stop breathing, gasping or Struggling to breathe during your sleep? _____	☐ (1pt)	☐	☐
7. Have you been diagnosed with or do you require treatment for <u>HIGH BLOOD PRESSURE?</u>	☐ (1pt)	☐	☐
8. Have you been diagnosed with or treated for any of the following: ☐ Atrial Fibrillation/Arrhythmia ☐ Heart Attack or Stroke ☐ Diabetes	☐ (1pt)	☐	☐

(Sum of all 'Yes' scores above) Total Score:	N/A	N/A	
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<u>EPWORTH SLEEPINESS SCALE:</u> Please rate your likelihood of dozing in the following situations:	Never would doze off	Slight Chance of dozing	Moderate Chance of dozing	High Chance of dozing
1. Being a passenger in a motor vehicle for an hour or more:	0 ☐	1 ☐	2 ☐	3 ☐
2. Sitting and talking to someone :	0 ☐	1 ☐	2 ☐	3 ☐
3. Sitting and reading:	0 ☐	1 ☐	2 ☐	3 ☐
4. Watching T.V. :	0 ☐	1 ☐	2 ☐	3 ☐
5. Sitting inactive in a public place:	0 ☐	1 ☐	2 ☐	3 ☐
6. Lying down to rest in the afternoon:	0 ☐	1 ☐	2 ☐	3 ☐
7. Sitting quietly after lunch:	0 ☐	1 ☐	2 ☐	3 ☐
8. In a car, while stopped for a few minutes in traffic:	0 ☐	1 ☐	2 ☐	3 ☐

(Sum of all numbers checked above) Total Score _____ / 24	
Add 1 Point if score is 10 or higher _____	

Insurance: _____	Total Score (2 or more = Positive): _____
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Provider Notes to Sleep Coordinator:

☐ Proceed w/ Home Sleep Test
 ☐ Patient Declined HST
 ☐ Other: _____

Diet Diary

Track 4 days of typical eating and drinking habits below.

	Day 1	Day 2	Day 3	Day 4
Breakfast				
Snack				
Lunch				
Snack				
Dinner				

Robin E. Moore, N.D.

Naturopathic Physician

3773 C Martin Way E, Suite 102

Olympia, Washington 98506

Phone- 360-459-9082 Fax- 360-459-4262

To Our Clients:

Please keep us informed of any change in address, phone numbers or any and all changes with your insurance coverage. Remember we are happy to assist you in the insurance process, but the ultimate responsibility lies with you, the client.

Please remember to bring any and all relevant labs/imaging to get the most out of your visit with Dr. Moore.

Helpful tips for your insurance coverage:

Before your initial visit, please contact your insurance carrier to clarify your benefits and coverage. Document the date and time of each call and the name of the person you spoke with.

Some Questions to Ask:

1. Is a Naturopathic Physician and/or alternative care covered by my individual plan?
2. Am I required to see a preferred provider (PCP) and does my insurance recognize the provider I will be seeing as preferred?
3. Do I need a written referral if I have a primary care provider (PCP)?
4. Is there a limit on the number of visits per calendar year or a dollar amount?
5. What, if any, deductible do I have at the beginning of each calendar year?

Billing Procedures:

We will bill your insurance for treatment if Dr. Moore is contracted with your insurance company. Once your insurance has paid, you will be billed for any outstanding balance indicated by your carrier. Payment for the full outstanding balance is expected upon your receipt of that billing unless other arrangements have been made with our office.

If you have any further questions, please don't hesitate to ask!

Thank you.

Robin E. Moore, N.D.

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Olympia, Washington 98506

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND SIGN.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any relayed services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirement, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements in Section 164.500.

Other permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction on your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Complaints

You may complain about us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our privacy contact of your complaint.

We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practice with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Name: _____ Signature: _____ Date: _____

Robin E. Moore, N.D.
3773 C Martin Way E, Suite 102
Olympia, Washington 98506
Phone- 360-459-9082 Fax- 360-459-4262

Office Policies

Welcome to Olympia Family Health. The following is a list of office policies designed to help the office run efficiently while meeting your needs.

Please initial the spaces indicated to show that you have read and agree to each policy.

If you have any questions or comments about these policies, please feel free to share them with us. If you have any questions about Naturopathic philosophy, training, diagnostics, or the scopes of practice, please refer to my brochure.

Telemedicine

- A. Please be considerate of my time by having the receptionist answer or relay your question(s) if possible. Initial _____
- B. We utilize teleconferencing (secure video call) for appointments that do not require an exam. Telemedicine appointments are covered by most insurances. otherwise, the out-of-pocket price is the same as a usual appointment. Initial _____
- C. I **cannot** prescribe prescriptions over the phone for someone who is not an established patient. Initial _____

Emergency Calls

You are welcome to call me for emergencies if needed. An emergency is when you have a health problem which you think is serious enough that it cannot wait until the next working day. Please be considerate with your judgment in such situations.

There is a minimum charge of \$45 for after-hours phone calls. Initial _____

Payment

Full payment is expected at the end of each appointment and for pharmacy items at the time of pickup. We accept cash, checks, Visa, and MasterCard. If you have insurance that covers Dr. Moore, you will need to pay your copay and pharmacy items at the time of the visit. Bring your insurance card with you and complete an insurance billing form for our billing department annually. **Note: we do the billing only for specific insurance companies that we are contracted with.** If you have coverage through a non-contracted insurance, you will need to pay for your office call and/or pharmacy at the time of your visit. We will then provide you with an "insurance ready" receipt which you can submit for your personal reimbursement.

Initial _____

Children In The Office

If your child is not the reason for your appointment or they are not old enough to occupy themselves in the waiting room, please make other arrangements for their care or have someone accompany you to your visit. Young infants whom you cannot leave are welcome.

Initial _____

NSF Checks

There will be a **\$50.00** charge on all NSF checks. Upon receipt of an NSF check, we will contact you and arrange for re-payment the following week.

Initial _____

Pharmacy Refills

If you are refilling a prescription, please try to bring the container with you for refill. This does not apply to pre-packaged items with company labels. We will only dispense pharmacy to established patients and only pharmacy items that have been recommended by the doctor. All pharmacy must be paid for at the time of pickup.

Initial _____

Missed Appointments-Late Cancellations

Missed appointments or cancelations with less than a 24-hour notice will be charged **\$50.00**.

Initial _____

Thank you very much for reading and following our office policies. I realize that policies can seem very cut and dry, but they also allow my medical services to be more efficient. Also, thank you for your interest and support in Naturopathic medicine.

Sincerely,

Robin E. Moore, ND

Patient Registration

Olympia Family Health
Robin E. Moore, N.D.
3773 C Martin Way E, Suite 102
Olympia, WA 98506

Date: _____ Cell Phone () _____ Home Phone () _____

Patient: _____

Last Name

First Name

Middle Initial

Responsible Party (If a minor): _____

Street Address: _____ Email: _____

City: _____ State: _____ Zip: _____ M F Date of Birth: _____

Name of Primary Physician (PCP): _____

Preferred Pharmacy: _____

Employer: _____ Occupation: _____ Work Phone: _____

Which numbers may we leave appointment reminders and/or Medical Content at? (Please check boxes)

☐ Home ☐ Work ☐ Cell ☐ Text Other: _____

You may share general information with the following person: _____

Relationship: _____ Date of Birth: _____

PLEASE PROVIDE YOUR INSURANCE CARD(S) TO COPY

Do you have **Medicare**? Yes ____ No ____

Name of Primary Insurance: _____ Policy Holder: _____

Subscriber/ID# : _____ Group # : _____

Name of Secondary Insurance: _____ Policy Holder: _____

Subscriber/ID# : _____ Group # : _____

In Case of Emergency Contact: _____

Relationship: _____ Phone Number: _____

Authorization: Insurance Acknowledgement & Release

I certify that I have insurance coverage and assign directly to Robin E. Moore N.D. all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible** for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for the related services. This consent will end when my current treatment plan is completed or one year from date of signed below.

Signature and printed name of Beneficiary, Guardian or Personal Representative

Date Signed