Interactive HEALTH CLINIC
Proactive Medicine that Rejuvenates You
16108 Ash Way, Suite 109 Lynnwood, WA 98087 425.361.7945

Date: _____

Intake Form

Name: _____ Date of Birth: _____ Gender : _____

Social Security #:_____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone (home): (_____) _____ (Work/Cell): (_____) _____

As the above are not considered "secure" communication devices and HIPAA regulations require permission

- **Is it acceptable for us to contact you via e-mail?** **YES** ☐ / **NO** ☐
- **Is it acceptable for us to leave messages on a voice mail / answering machine for you?** **YES** ☐ / **NO** ☐

Education:_____ Occupation: _____ Hours/week: _____

Employer:_____ Work Address: _____

Status (circle): Single Married Separated Divorced Widowed Partnership

Live with (circle): Spouse Partner Parents Children Friends Alone

Race/Ethnic Origin (circle): African African American/ Black Amer. Asian Caucasian
Native American Pacific Islander Native Hawaiian Hispanic Other

Spouse or Emergency Contact

Contact Name:_____ Date of Birth: _____ Relationship to you:_____

Telephone (home): (_____) _____ (Work/Cell): (_____) _____

Employer: _____ Work Address: _____

Name of parent(s) or guardian(s):_____

How did you hear about this clinic?

Friend _____ Patient _____ Physician _____ Insurance Carrier _____

Web: ○ Google ○Yahoo ○Yelp ○ Bing ○ Facebook ○ Other _____

Have you ever seen a Naturopathic Doctor (ND) before? Y ☐ / ☐ N

Are you currently receiving healthcare? Y ☐ / N ☐ If yes, where and from whom? _____

If no, are you planning to establish primary care with us? Y ☐ / ☐ N

Primary Insurance Company: _____ ID#: _____ Group#: _____

Name of Policy Holder: _____ Birthdate: _____

Co-Pay: _____ Co-Insurance: _____

Policy Holder's Relation to Patient: _____

Secondary Insurance Company: _____ ID#: _____ Group#: _____

Name of Policy Holder: _____ Birthdate: _____

Co-Pay: _____ Co-Insurance: _____

Policy Holder's Relation to Patient: _____

CONTEXT OF CARE REVIEW

What do you know about our approach?

What **three** expectations do you have from **this** visit to our clinic?

1.
2.
3.

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list)

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive? (Please list)

What do you love to do?

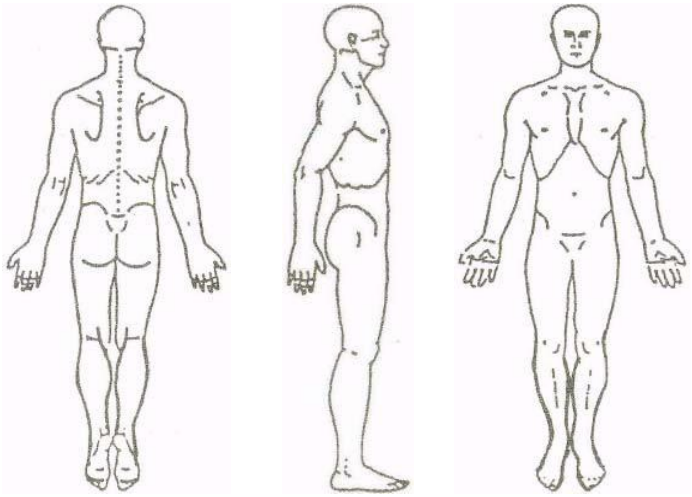
Current Problem List

What are your most important health problems? List as many as you can in order of importance and include time of onset.

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

Please list any current diagnoses:

1. _____
2. _____
3. _____
4. _____



Please mark your areas of pain

Please indicate your CURRENT pain level.)

Select

Do you have any known contagious diseases at this time? Y☐ N☐
If yes what?_____

What treatments have you tried for the above concerns? _____

_____

_____

General Information

Height: _____ Weight:_____ Weight one year ago? _____ Maximum weight and when _____

Exercise? Y☐ / N☐ If so, what kind and how often? _____

Do you watch TV? Y☐ / N☐ If yes how many hours? _____ Do you read? Y☐/ N☐if yes how many hours? _____

When and where did you last receive medical or health care? _____ What was the reason?_____

When was your last: Blood tests: _____ Eye Exam: _____ Dentist Visit: _____

If child (child visit): _____ If male (prostate exam/PSA): _____

If female: Pap _____ Physical Exam _____ Breast Exam _____ Mammogram: _____

Current on vaccinations? Y☐ / N☐ / Choose not to do vaccinations ☐

Allergies: *(Please list ALL your known ALLERGIES (DRUGS, FOOD, INSECTS, ANIMAL, ETC)) and what happens:

_____

_____

Food Reactions: What foods do you react to and what reactions do you have? _____

_____

***A medications, including over the counter**

Medications	Dose / Frequency		Start Date

Supplements	Dose / Frequency		Start Date

Have you taken Aspirin, Ibuprofen, Naproxen, or any steroids for a long period of time (3 weeks or longer)? Y☐ / N☐

Do you have a history of taking antibiotics? Y☐ / N☐ If yes for how long and what for? _____

Environmental History

Do you have amalgam fillings? Y☐ / N☐ If yes, how many and for how long? _____

Do you have past or current history of work related chemical exposures? Y☐ / N☐ If yes what chemicals? _____

Any known heavy metal exposures Y☐ / N☐ If so what? Any known tick bites? Y☐ / N☐

Any known exposure to mold/ water damaged building? Y☐ /N☐

Hospitalizations / Surgery / Imaging:

Please list, examples: X-ray, CAT scans, EEG, EKGs or MRI

_____ Year

_____ Year

_____ Year

_____ Year

_____ Year

Family History (Check those that apply)

	Sibling	Mother	Father
Diabetes			
Cancer			
Heart Disease			
Stroke			
Autoimmune			

Typical Food Intake (WHAT DO YOU EAT?)

Breakfast:

Lunch:

Dinner:

Snacks:

Please list # of ounces consumed per day below

Water: ____oz Coffee: ____oz Alcohol: ____oz

Current Smoker: Y☐ /N☐ How many packs per day?

Past Smoker ? Y☐ / N☐

***Circle* things you eat MORE than 3 times a week:**

TUNA / OTHER FISH ◯ RED MEAT ◯

RAW VEGETABLES ◯ CHEESE ◯

WHEAT PRODUCTS ◯ SOY PRODUCTS ◯

RAW NUTS/SEEDS ◯ POULTRY ◯

Please add comments as needed to clarify the symptoms listed, leave blank any which do not apply.
(SELECT) P = Past C = Current * = Major problem

Head:

Select Headaches/ Migraines
Select Dizzy
Select TMJ/ Jaw pain

Skin/Nails/Hair

Select Dry skin/scalp
Select Rash
Select Acne
Select Cracking nails
Select Hair loss
Select Hair growth

Eye/Ear/Nose/Throat

Select Blurry vision
Select Dry eyes
Select Dark circles under eyes
Select Hearing loss
Select Ringing in ears
Select Sinus pain/ infection
Select Nose/ Nose runs/sinuses dry
Select Loss of smell
Select Seasonal allergies
Select Post nasal drip/Nose bleeds
Select Voice hoarse
Select Sore throat
Select Neck lumps
Select Difficulty swallowing

Chest:

Select Heart pounds
Select Heart "flutter"
Select Shortness of breath
Select Asthma (Triggered by _____)
Select Chest pains
Select Wheezing
Select Coughing

Gastrointestinal

Select Heartburn
Select Stomach aches
Select Gas/ Bloating
Select Fatty meals make worse
Select Constipation
Select Diarrhea
Select Blood or Mucus in stool
Select Vomiting
Select Hemorrhoids
Select Increased appetite
Select Decreased appetite

Bowel movements per day _____

Urinary Tract

Select Bladder infections
Select Kidney infections
Select Burning with urination
Select Frequent urination
Select Blood in urine
Select Urinary incontinence

Musculo-skeletal:

Select Joint pains
Select Back pain (UPPER / LOWER / ALL)
Select Neck Pain
Select Muscle aches
Select Bruising (EASY) (ONLY W/TRAUMA)
Select Sprains Locations: _____
Select Joint stiffness
Select Arthritis
Select Fibromyalgia diagnosis: When:

Neuro-Endocrine

Select Panic / Anxiety attacks
Select Irritability
Select Feel bad when skip meals
Select Depression
Select Problems with concentration
Select Weight gain
Select Weight loss
Select Mood swings
Select Snack often
Select Increased thirst
Select Insomnia
Select Feel restless at bedtime
Select Wake up easily at night
Select Cold hands and feet
Select Night sweats

Energy

Select Sleep soundly
Select Wake feeling rested
Select Easy to fatigue
Select Poor memory
Select Slow starter
Select Afternoon tiredness
Select Tired all day

Sexual History

Practice Safe Sex Practices YES ☐ NO ☐
Partners: Male ☐ Female ☐ BOTH ☐
Tested for STDs: _____

Male ONLY: (Circle what applies to you)

Frequent urination: DAY / NIGHT
Select Incomplete urination
Select Discharge from urethra
Hernias: CURRENT ☐ PAST ☐
Select Decrease in sex drive
Select Erectile difficulty
Select Hernias

My **energy** level weekly averages: Select 2-3-4-5-6-7-8-9-10 (HIGH)
My **stress** level weekly averages: Select 2-3-4-5-6-7-8-9-10 (HIGH)

Female ONLY: (Circle what applies to you)

Duration: 1 - 2 - 3 - ALL: Weeks before menses
4 Heavy flow
4 Painful menses
Select Light flow
Select Changes in duration, regularity
Average cycle length: _____
Average menses length: _____
Date last menses started: _____
Menopause Began: _____
Age your mother entered menopause? _____
Select Decrease in sex drive
Select Vaginal discharge
Select Yeast infections
Select Hot flashes
Select Acne (AT) / (BEFORE) menses
Select Pain in breasts (WITH CYCLE)/ (CONSTANT)
Select Difficulty in (Conception, Carrying to term)
Number of Pregnancies: _____
Number of Births: _____

CONSENT FOR TREATMENT

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Interactive Health Clinic, PLLC having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, _____, hereby request and consent to examination and treatment with Naturopathic Medicine by doctors at Interactive Health Clinic, PLLC and/or other licensed Doctors of Naturopathic Medicine serving as backup for doctors of Interactive Health Clinic, PLLC, hereafter called *allied health care provider*. I can request that students and preceptors not be included in my evaluation and treatment.

(Initial) _____ I acknowledge that the clinic or practice of Interactive Health Clinic, PLLC including its doctor(s) and staff, are distinctly and completely separate from (1) the doctor and or clinic and their staff that referred me, and or (2) the premises of the doctor(s) and or clinic in which care is being rendered.

I understand that I have the right to ask questions and discuss to my satisfaction with any doctor at Interactive Health Clinic, PLLC and/ or with the *allied health care provider* providing backup:

(1) my suspected diagnosis(es) or condition(s)
(2) the nature, purpose, goals and potential benefits of the proposed care
(3) the inherent risks, complications, potential hazards or side effects of treatment or procedure
(4) the probability or likelihood of success
(5) reasonable available alternatives to the proposed treatment procedure
(6) potential consequences if treatment or advice is not followed and/ or nothing is done

I understand that a Naturopathic evaluation and treatment may include, but are not limited to:

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Common diagnostic procedures (including venipuncture, pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Soft tissue and osseous manipulation (including therapeutic massage, deep tissue massage, neuro-muscular technique, naturopathic/osseous manipulation of the spine and extremities, muscle energy technique, visceral manipulation and cranio-sacral therapy)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
- Injection therapies such as but not limited to: Trigger point injection therapy with vitamin substances, Neural Therapy (scar, trigger point, deeper injections with procaine and homeopathic substances), Perineural Injections (Neural Prolotherapy) (subcutaneous, intramuscular, intra-articular, sweet caudal), and Prolotherapy/Prolozone (subcutaneous, intra-muscular, intra-articular, ligaments and tendons), Biological allografts, Platelet Enriched Plasma, Ozonated Clot Matrix.
- Intravenous therapy (nutrient therapy where fluids with vitamins, minerals, amino acids, botanicals, antioxidant compounds, ozone therapies that are administer by placing a needle in the arm)
- Intravenous and/or oral chelation therapy with substances such as but not limited to (DMPS, EDTA, DMSA, TM)
- Botanical/ herbal medicines/ Homeopathic remedies (prescribing of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, capsules, creams, powders, tinctures which may contain alcohol, suppositories, pastes, plasters, washes or other forms
- Sweet Nasal
- Hydrotherapy (use of hot and cold water, may include transcutaneous electrode stimulation)
- Counseling (including but not limited to visualization for improved lifestyle strategies)
- Over the counter and prescription medications (including only those medications on the Formulary of Washington Naturopathic Physicians)
- Weight loss therapies not limited to, but may include, HCG, Ideal Protein and Ketogenic diet.
- PEMF, Ultrasound and Shockwave

Potential risks: Pain, fracture, stroke, dislocation, sprain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, hydrotherapies; allergic reaction to prescribed herbs, supplements, prescription medications; soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms.

Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

(CONTINUE TO THE BACK SIDE)

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy. Labor- stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor and any treatment intended to induce labor requires a signed letter from a primary care provider authorizing or recommending such treatment.

Notice to individuals with bleeding disorders, pacemakers, and/ or cancer. For your safety it is vital to alert your provider, of these conditions.

Please Read And Initial:

_____ I understand that doctors at Interactive Health Clinic, PLLC are not licensed to prescribe any controlled substances other than Tylenol III (codeine) or Testosterone.
_____ I understand that doctors at Interactive Health Clinic, PLLC will only prescribe medications that are in the best interest of myself, the patient. Appropriate referrals will be provided to manage my prescriptive medication needs.
_____ I understand the US Food and Drug Administration has not approved nutritional, herbal, homeopathic substances, bioidentical hormones, biological allograft/stem cells, injection therapies or nutrient infusion therapies; however these have been used widely in Europe, China and the USA for years.
_____ I understand that doctors at Interactive Health Clinic, PLLC are not licensed as psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies.
_____ I understand that doctors at Interactive Health Clinic, PLLC offer many therapies that are considered purely investigational/experimental.
_____ I understand that doctors at Interactive Health Clinic, PLLC offer many integrative oncology therapies that are considered purely investigational/experimental. Interactive Health Clinic does not ensure cure of any disease and encourages the you to work with your oncologist.

I do not expect Interactive Health Clinic, PLLC and/or any *allied health care provider* to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that the doctor at Interactive Health Clinic, PLLC explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below, I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand that I am responsible for knowing where my personal items are at all times while in the office and if I choose to remove or place any of my personal items I am voluntarily and Interactive Health Clinic, PLLC and its associated doctors are NOT responsible or liable for any lost, stolen, or misplaced items. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment

_____ _____
Printed Name of Patient Signature of Patient

_____ _____
Printed Name of Guardian Signature of Guardian

_____ _____
Date Signed Print Provider's Name

FINANCIAL AGREEMENT

Welcome to Interactive Health Clinic. We look forward to providing your health care needs. We encourage your questions and participation in all aspects of your care. **MEDICARE DOES NOT COVER SERVICES OR SUPPLIES PROVIDED IN THIS OFFICE.**

_____**(Initial) Visits:** Naturopathic office visits vary depending on time and complexity. Allow up to 50 minutes for the first visit and up to 25 minutes for return visits. For an estimate on pricing please contact our office. **All office visits that exceed the allotted time will be assessed an extended visit charge. Insurance coverage for extended visits varies. Consult with your insurance to determine your coverage.**

_____**(Initial) Credit Card ON File:** A credit card on file will be required to schedule visits. See credit card form.

_____**(Initial) Email and Electronic Medical Records Messaging:** Email is a convenient way to get questions answered in lieu of coming in for an appointment. **PLEASE NOTE:** Emails are **NOT** covered by insurance and are **NOT** considered secure means of communication. EMR messages are secure but don't replace a visit with the physician. Emails/EMR messaging are complimentary for scheduling, confirmation of dosage, billing, etc. **1 complimentary message between visits** pertaining to quick yes/no or quick questions between visits with the doctor is permitted. Additional message will be billed accordingly OR will fall under the guidelines of the membership. Inquire about membership package if further support is needed.
The following fee schedule applies to those who wish to pay per occurrence versus membership:

- 3 to 10 minutes: $200
- 11 to 20 minutes: $250
- 21 to 30 minutes: $350
- 30 to 50 minutes: $450

_____**(Initial) Prior Authorizations:** These are becoming more prevalent and takes extended amounts of time and money that our office does not have the resources for. Any prior authorizations that take over 10 minutes of our office staffs time will be billed at $150 per hour to you the patient and is NOT insurance reimbursable. You can actively participate in this process to avoid fees.

_____**(Initial) Legal Paperwork, Letters, and Forms:** These are complimentary if associated directly with a visit. Forms outside of the clinic visit will be billed $20 for the first page and $10 per additional page.

_____**(Initial) Cancellation Policy:** New patients will be charged a $100 fee with late cancellations less than 72 hours, return patients will be charged a $100 fee with late cancellations (within 24 hours). The full fee will be charged for same day cancellations or if no notice is received before the appointment time. Missed IVs that have been mixed prior to your arrival will be charged the full amount of the infusion. IV bags are mixed accordingly in the morning at 9 am.

_____**(Initial) Prescription or Supplement Refills:**
If you need a refill on a prescription that you received from a pharmacy, please call your pharmacy and have them fax us a refill request. If you need a refill on supplements that you received from our office, please email info@interactivehealthclinic.com and someone will follow up with you within 72 hours. Visits and labs may be required to refill specific prescriptions. Memberships will have expedited refills during that business day.

_____**(Initial) Payment:** Payment for visit co-pays and/or medication, supplements, supplies is due at time of service made by credit card (Visa and MasterCard ONLY), cash, or check. If you are a cash patient, a Time of Service discount of 10% will be applied only on the day of service. If payment occurs after the date of service, the discount will be removed. If medications/supplements are mailed to you, a postage and handling fee will be added to the cost. Refunds or exchanges are given on unopened items in re-sellable condition if returned within 30 days. No refunds or exchanges will be given of opened items. Refunds are NOT provided on Special Order Supplements that are not commonly stocked. Returned checks, declined cards or rejections due to not informing the office of changes in insurance coverage will be subject to a $50.00 NSF fee. You are responsible for all balances due that are not covered by your insurance company. Any ongoing bills that are not paid within 30 days are subjected to 12% per year (1% per month) interest charges. Outstanding balances greater than 120 days will be turned over to a collection agency unless prior arrangements have been made in writing. If Interactive Health Clinic assigns your account to a collection agency, you will be responsible for any collection fees.

I HEREBY ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED, LABS ORDERED, AND THAT I AM SUBJECT TO ALL FINANCIAL TERMS LISTED BELOW. ALL THERAPIES AT INTERACTIVE HEALTH CLINIC ARE CONSIDERED INVESTIGATIONAL/EXPERIMENTAL AND CAN BE DENIED BY INSURANCE COVERAGE.

I understand that all co-pays and medications are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that some third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Interactive Health Clinic, PLLC (and all physicians working with Interactive Health Clinic, PLLC) to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

Acknowledgement of Non-Insurance Coverage for Services Rendered

I agree, and it has been explained to me, that the following services performed at the Interactive Health Clinic are not generally considered and accepted with respect to insurance coverage with the exception of the infusion portion of iron infusions. Usual and customary Evaluation and Management or other medically necessary services may be billable to my insurance dependent upon my particular plan, but IV / Injection services and supplies, supplements and other supplies such as Kinesio Tape cannot be billed. I understand that most insurance carriers cover an inferior and less safe Iron IV product. The clinic purchases a superior Iron IV product that is twice the cost of the inferior iron; therefore, I agree to pay the Iron supplies to cover the cost. This is not a profit driven cost, this is for patient safety.

I understand that this requires my payment in full for all IV / Injection services, supplies, supplements and I additionally understand that I may not attempt to bill my own insurance company for any of these services.

I (Print Name) _____ agree to the above defined financial policies of Interactive Health Clinic, PLLC (and all physicians/doctors associated). In the case of default of payment, I am responsible for full payment of the balance, interested accrued, and any collection costs and legal fees incurred to collect this account. I have filled out and understand the scope and limitations of my insurance coverage and agree to pay all fees not covered by my insurance plan. I, the undersigned, have read, understand, and accept the information and conditions hereby specified. **I AM FULLY RESPONSIBLE FOR ALL COSTS INCLUDING LABS, VISITS, OR TREATMENT PROCEDURES THAT ARE PERFORMED AT INTERACTIVE HEALTH CLINIC. INCLUDING ALL COSTS DENIED BY MY INSURANCE.**

_____ _____
Patient's Print and Signature Date

_____ _____
Person responsible if other than Patient – Please Print and Signature Date

FOR YOUR INFORMATION ONLY
YOU DO NOT NEED TO FILL THIS OUT.

Patient Responsibility and Insurance Information Form

We understand that it can be difficult to determine the cost of your insurance plan and they may not always cover our services. The purpose of this form is to help you fully understand your health insurance package and enable you to get the most from it.

Some policies have deductibles; this is the amount you pay on a claim(s) before your insurance begins paying. Some have in-network benefits that are covered at a higher percentage than out-of-network benefits (which may have a substantial deductible).

Please call your insurance company and fill out the following information. By understanding your benefits you will understand the scope and limitations of your coverage. You will reduce surprise costs as you are solely responsible for any services not covered under your specific insurance plan.

Your Name: _____ DOB:_____ Today's Date:_____
Insurance Company: _____ Insurance ID#:_____
Group Number: _____
When did my coverage begin and when is it valid thru? Beginning Date: _____ Ending Date: _____

Naturopathic Benefits:

1. Do I have naturopathic doctor coverage? (circle) Yes ☐ / No ☐
2. What percent does insurance cover? _____
3. What percent am I responsible for? _____
4. Is a referral required? Yes /No ☐ ☐
5. Do I have a co-pay? Yes/No (If yes what is my co-pay) _____
6. Do I have a deductible? Yes/No (If yes how much) _____
7. Has my deductible been met? Yes ☐ /No ☐ (if yes how much)
8. Do I have preventative care coverage? Yes ☐ /No ☐
9. Does this include routine lab work with "V" codes? Yes ☐ /No ☐
10. Are there any exclusions? Yes ☐ /No ☐
11. Do I have a coinsurance? Yes ☐ /No ☐ (if yes what is my max) _____

Diagnostic Testing

1. Am I covered for diagnostic testing? (circle) Yes ◯ /No ◯
2. What percent does insurance cover? _____
3. What percent am I responsible for? _____
4. Is referral required? (circle) Yes ◯ / No ◯
5. Do I have a deductible? (circle) Yes ◯ /No ◯ (if yes what is my deductible) _____
6. Has my deductible been met? (circle) Yes ◯ /No ◯ (if yes how much) _____
7. Are there any restrictions for testing? (circle) Yes ◯ /No ◯
8. Are there any exclusions? (circle) Yes ◯ /No ◯
9. Do I have a coinsurance? Yes ☐ /No ☐ (if yes what is my max) _____

If you have insurance through someone else (your spouse, parent, other) and your name is not on the insurance card, please fill out the following for the main person on the policy:

Name:_____ Birth date:_____
Address (if different from yours): _____
Employer: _____

What was the name of the representative I spoke with: _____ Date: _____

Please be aware that this is not a guarantee of payment. If an insurance company gives you inaccurate information, they may not honor the benefits that were quoted. Your insurance may not pay for tests or other services that may be needed for your best treatment. Doctors at Interactive Health Clinic will discuss these labs and services with you ahead of time whenever possible. By signing below, you are agreeing to pay for any testing or services that are not covered by your insurance policy and you are agreeing to not hold Interactive Health Clinic responsible for payment of non-covered services