Authorization to Bill Third-Party Payer

Patient Name: _____ Date of Birth: _____

SECTION 1: Benefits and Billing Information

~ Please notify the front desk staff if your visit is related to an injury or accident ~

I. Does your insurance have alternative medicine benefits? □ Yes □ No

What is your co-pay for an office visit?: $_____

Who is your Primary Care Provider?: Dr. _____ Clinic Phone #: (_____)_____

Clinic Address: _____ City:_____ State: _____ Zip Code: _____

Does your plan require you to have a referral from you Primary Care Provider to receive coverage? □ Yes* □ No

II. Primary Insurance Company & Plan Name: _____

ID Number: _____ Group/Policy Number: _____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

The policy holder is my: _____ (specify relationship) Policy Holder's Gender (circle): Male Female

Is your Primary Insurance Policy a: □ POS □ PPO □ EPO □ HMO □ Don't Know Other (specify): _____

III. Secondary Insurance Company & Plan Name: _____

ID Number: _____ Group/Policy Number:_____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

The policy holder is my: _____ (specify relationship) Policy Holder's Gender (circle): Male Female

Is your Secondary Insurance Policy a: □ POS □ PPO □ EPO □ HMO □ Don't Know Other (specify): _____

SECTION 2: 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: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: (_____)_____

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 below.

X _____ _____

Guarantor's Signature **Date**

I understand that all co-pays 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 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 Dr. Tamar Blau 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.

X _____ _____

Patient's Signature Date

X _____ _____

Guardian/Representative's Signature Date

_____

Relationship to Patient/Representative Authority

CONSENT FOR TREATMENT

Description of Naturopathic medicine: Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional, and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

Your Naturopathic Doctor will take a thorough case history, do a complete physical examination as indicated, and may take blood and urine samples. If your case requires, the physical exam may include more specific examination such as respiratory, cardiac, abdominal, musculoskeletal, neurological, gynecological, rectal, prostate or genital exams.

It is important that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, and if you are on any medication, over the counter drugs or supplements. If you are pregnant, suspect you are pregnant, or you are breast-feeding, please advise your Naturopathic Doctor immediately.

Methods, Procedures and Therapeutic Approaches: These may include, but are not limited to: herbs/natural medicines, pharmaceutical medications, psychological and/or lifestyle counseling, homeopathy, exercise prescriptions, dietary advice, therapeutic nutrition, hydrotherapy, soft tissue, and physical manipulations. Please initial the following:

_____ Consent to Injections: I consent to all injection procedures rendered by the doctor who is now or will in the future treat me while employed by or associated with this practice. I understand there are risks to injections including but not limited to severe pain, bruising, inflammation, injury, numbness, allergic reaction and infection. I do not expect the doctor to anticipate and or explain all risk and possible complications. I rely on the doctor to exercise judgment during the course of treatment with regards to any procedure. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek 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.

Potential Risks: Naturopathic medicine is a generally safe method of treatment, but may have some side effects. Risks include but are not limited to: pain, bruising, infection, loss of consciousness from needle insertions (blood draw), topical procedures, and hydrotherapies; allergic reactions to prescribed medications, herbs or supplements; aggravation of pre-existing symptoms; and soft tissue or bone injury from physical manipulations.

Prescribed Supplements and Medications: The herbs, remedies and nutritional supplements recommended are traditionally considered safe, however some may be toxic in larger doses. The medications, herbs, remedies and supplements should be consumed according to the instructions provided orally and in writing. Please notify the doctor listed below immediately of any unanticipated or unpleasant effects associated with the herbs, remedies or supplements.

Health records: A record will be kept of the health services provided to you. This record will be kept confidential and will not be released to others unless so directed by you or your representative or otherwise permitted or required by law. You may arrange a time to look at your medical records during the clinic's business hours and can request a copy of it by paying the appropriate fee.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of naturopathic medicine and other procedures, and have had an opportunity to ask questions. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Tamar Blau, ND, Roots Naturopathic Medicine PLLC, or any of its personnel regarding cure or improvement of my condition. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

X_____ _____ X_____ _____

Patient's Signature Date Guardian/Representative's Signature Date

_____ _____

Print patients name Relationship to Patient/Representative Authority

Naturopathic Doctor: Dr. Tamar Blau, ND at Roots Naturopathic Medicine, PLLC

NOTE THAT THIS FORM MUST BE SIGNED

Dr. Tamar Blau, N.D.

Assignment of Responsibility for Payment and Payment Agreement

Welcome to the private practice of Dr. Tamar Blau, ND. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care. Please read and initial the following statements:

_____Payment for all services and medicinary items is due at the time of the visit. We accept cash, checks and credit cards. Returned checks will be subject to a $35.00 NSF fee.

_____Phone calls and emails regarding an existing health issue that require more than 10 minutes of attention from your physician will incur a $25 fee. Phone calls and emails regarding a new health issue, regardless of the length of time of attention required, will also incur a $25 fee. Your physician will notify you of the need for a charge, so that you can determine whether you would like to address the issue and pay the fee, or schedule an appointment. The $25 fee will cover multiple phone conversations dealing with the same medical issue. Phone and email charges are not billable to insurance.

_____You will be charged a Missed Appointment Fee of $50.00 for any missed appointments or late cancellations (less then 24 hours notice).

_____Your health care provider may prescribe medication, which may be purchased at the clinic or elsewhere. Most insurance companies do not cover the pharmacy items that we prescribe and dispense.

I have read and understand the above-stated policies of Dr. Tamar Blau and Roots Naturopathic Medicine, PLLC, and will comply with them in all respects. I understand that I am financially responsible for the services provided to me by Dr. Tamar Blau, N.D. regardless of insurance coverage. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

_____ Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ _____/_____/_____

Patient Signature Date

Dr. Tamar Blau, N.D.
Roots Naturopathic Medicine, PLLC

4010 Stone Way N
Suite 300
Seattle, WA 98103
Ph. (206) 972-2271
Fax (206) 965-9081
drtamarblau@gmail.com
www.rootsnaturopathic.com

Dr. Tamar Blau, N.D.
Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been provided with a copy of Dr. Tamar Blau, N.D.'s Notice of Privacy Practices on this date.

_____ _____
Date Signature

_____ _____
Patient Representative's Signature Relationship to Patient

Patient unable to sign because:

_____
PRINT NAME OF PATIENT

_____
Street Address

_____
City, State and Zip Code

Fee Schedule

Dr. Tamar Blau at Roots Naturopathic Medicine

Services	**Full Fee**	Discount if **paid in full** at time of service
ND visits (including fertility) • Initial Fertility visit: 90 min	375	280
• Initial ND visit: 60-75 min	250	195
• 45 min ND	190	145
• 30 min ND (most follow up visits)	125	95
• 15 min ND	100	65
After Hours Pager Use (Excludes insemination pages)	25 per use	25
Email/Phone **Clinical Questions:** See definition below	Less than 3 min = free **3 to 10 min follow up within 1 week of office visit= $25**	25
Email/phone consults more than 10 minutes for an established diagnosis, or more than 3 minutes to discuss a new health concern.	Standard visit fees apply as listed above	Standard visit fees apply as listed above
Ovulation/Cycle Chart Review:	25	25
Artificial Inseminations	300	250
2 Inseminations per cycle	500	425
• in-office, Mon - Fri, 9 am to 6 pm	Above fees	Above fees
Insemination Surcharges		
• in-office, Mon – Fri, after 6 PM	50	50
• in-office, weekends	75	75
• at-home (Downtown, North Seattle and shoreline)	75	75
• At-home (other areas)	150+ depending on distance	150+ depending on distance

Definitions:

- **Cash discount** = discount for paying in full at time of service (i.e. not billing insurance)
- **Email/phone/web forum clinical questions = unscheduled questions** from the patient that the physician feels is appropriate for phone or email and the physician does not request an scheduled visit for a more thorough assessment
- **Sliding Scale =** Please ask for our sliding scale fee list if you are in need of financial support.