**Dr Ryan Hosken, ND, RN**
**Complementary Physician, Nurse, & Counselor**

# New Patient Intake Form

**NWNDllc**
**3231 Broadway, Studio D**
**Everett, WA 98201**
**Tel: 206-954-4324**
**Fax: 206-299-0010**

DATE: _____

## Demographics

Name: _____ Phone (H or C): _____(W): _____
Street: _____ City: _____ State: _____ Zip: _____
Email Address: _____ Would you like to be emailed newsletter? Yes No
Age: _____ Birth Date: _____Gender: M F other: _____
Relationship Status: _____ # of Children: ____ Occupation: _____
Physician: _____ Physician's phone number: _____
Name of emergency contact: _____ Phone number: _____
Insurance carrier: _____ Insurance card number: _____

## Health Concerns

Please list your main reason for coming in today and other health concerns you have.
Main Complaint: _____
Others Health Concerns: _____
_____
Please describe other types of treatment you are receiving (massage, chiropractic, physical therapy, etc.)
_____
_____

## Past Medical History (include date):

**Significant Illnesses**:

__ Cancer_____ __ Diabetes_____ __ High blood pressure _____
__ Rheumatic fever _____ __ Thyroid disease_____ __ Hepatitis _____
__ Seizures_____ __ Other_____ __ Other _____

Surgeries: _____
Trauma: (auto accidents, falls, etc.) _____
Birth History: (prolonged labor, forceps delivery, etc.) _____
Allergies: (drugs, chemicals, foods.)_____
Date of last physical exam:_____ Please list any abnormal results:_____

Medications and supplements taken within the last two months (vitamins, over the counter drugs, herbs, etc.) 1
1 _____ 2 _____
3 _____ 4 _____
5 _____ 6 _____
Past medications used for any length of time (antibiotics, steroids, etc.): 1 _____
2 _____ 3 _____
4 _____ 5 _____

Please list any reactions you have had to medications, vaccines, and immunizations: _____
_____
_____

## Family Medical History (include date and which immediate family member/s):

**Significant illnesses:**

__ Cancer_____ __ Diabetes_____
__ Heart attack_____ __ Asthma_____
__ Seizures_____ __ Alcoholism_____
__ Hepatitis_____ __ Rheumatic fever_____
__ High blood pressure_____ __ Allergies_____
__ Stroke_____ __ Other_____

**Place an "X" if you have currently and a "P" if you have had in the past.**

### GENERAL HEALTH

__ Poor appetite __ Heavy Appetite __ Peculiar tastes/smells __ Heavy Sleep
__ Insomnia __ Fatigue __ Tremors __ Vertigo
__ Cold Hands __ Cold Feet __ Cold Back __ Cold Abdomen
__ Fevers __ Chills __ Night Sweats __ Sweat Easily
__ Cravings __ Localized Weakness __ Gastrointestinal __ Poor Coordination
__ Sudden energy drop at_____(time) __ Weight Changes _____
__ Strong thirst (cold/hot drinks)_____ __ Bleed or bruise easily (where)_____

Are you sexually active? _____ Type of birth control used:_____

*Comments:*_____

### SKIN AND HAIR

__ Rashes __ Ulcerations __ Hives __ Itching
__ Eczema __ Pimples __ Dandruff __ Loss of Hair
__ Change in hair/skin texture __ Purpura __ Current MRSA __ Previous MRSA
__ Other hair or skin problems_____

*Comments:*_____

### HEAD, EYES, EARS, NOSE, AND THROAT

__ Dizziness __ Concussion __ Migraines __ Glasses
__ Eye strain __ Eye pain __ Poor vision __ Night blindness
__ Color blindness __ Cataracts __ Blurry vision __ Earaches
__ Ringing in ears __ Poor hearing __ Nose bleeds __ Sinus Problems
__ Mucus __ Dry throat __ Dry mouth __ Copious Saliva
__ Teeth problems __ Jaw clicks __ Grinding teeth __ Facial pain
__ Gum problems __ Spots in eyes __ Recurrent sore throats_____/month
__ Sores on lips or tongue
__ Headaches (where and when)_____
__ Other Head or neck problems_____

*Comments:*_____

### CARDIOVASCULAR

__ High blood pressure __ Low blood pressure __ Chest pain __ Irregular heartbeat
__ Dizziness __ Fainting __ Cold hands/feet __ Difficulty breathing
__ Blood clots __ Phlebitis __ Swelling in hands/feet
__ Other _____

*Comments:*_____

**RESPIRATORY**

__ Cough __ Coughing blood __ Asthma __ Bronchitis __ Pneumonia
__ Tight chest __ Difficulty in breathing when lying down
__ Production of phlegm/_____color? __ Other lung problems_____

*Comments:*_____

**GASTROINTESTINAL**

__ Nausea __ Vomiting __ Diarrhea __ Undigested food in stool
__ Gas or bloating __ Belching __ Black stools
__ Bad breath __ Rectal pain __ Hemorrhoids __ Bloody stools
__ Constipation __ Heartburn __ Pain or cramps __ Mucous in stool
__ Sensitive abdomen
__ Laxative use:_____/week; type_____ How many bowel movements per day?_____

*Comments:*_____

**GENITAL-URINARY**

__ Pain on urination __ Frequent urination __ Blood in urination __ Urgency to urinate
__ Unable to hold urine __ Impotency __ Kidney stones __ Venereal Disease
__ Wake up to urinate: if so, how often_____/night

*Comments:*_____

**PREGNANCY AND GYNECOLOGY**

Number of pregnancies _____ Number of births _____ __ Premature births
__ Miscarriages _____ __ Irregular periods __ Menopause Age_____
__ Vaginal discharge __ Vaginal sores __ Breast lumps
__ Age at first menses __ Frequent yeast infections Last menses_____(date)
Flow/clots(describe)_____ Days between cycle _____
Date of last PAP: _____ Have you ever had an abnormal PAP? _____
If yes what were the results and outcome?_____
__ Changes in body/psyche prior to menstruation_____

*Comments:*_____

**MUSCULOSKELETAL**

__ Neck pain __ Muscle pain __ Back pain
__ Joint pains (where)_____ (how often) _____
__ Other joint or bone problems_____

*Comments:*_____

**NEUROPSYCHOLOGICAL**

__ Seizures __ Areas of numbness __ Poor memory __ Concussion
__ Depression __ Anxiety __ Bad temper __ Easily stressed
__ Treated for emotional problems __ Considered/attempted suicide
__Other neurological or psychological problems?_____

*Comments:* _____

*Additional Comments:* _____

_____

## NUTRITION

Please list the foods that you have eaten in the last 24 hours:

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____

_____

For liquids, please list how many 8 ounce cups per day or week.

Water _____ Fruit Juice _____ Vegetable Juice _____

Coffee (regular of decaf?) _____ Tea (black, green, herbal?) _____

Alcohol _____ Soda _____ Other _____

## LIFESTYLE PROFILE

How many hours per day or week do you work/attend school? _____

What do you do for exercise and how often? _____

_____

How many hours per night do you sleep? _____ Do you wake feeling well rested? _____

On a scale on 1-10, 1 being low, 10 being high, how is your overall energy? _____

When is your energy lowest? _____ Highest? _____

What is your stress level? _____ How do you relax? _____

Where in your body do you hold stress? _____

Do you smoke or have you in the past? _____ How much? _____

## ADDITIONAL INFORMATION

*Please add any additional information you would like me to know (or additional medications you are taking):*

NWNDllc Dr Ryan Hosken, ND, RN, 3231 Broadway, Everett, WA 98201, Phone: 206-954-4324

# Time and Fee Structure

| | | |
|---|---|---|
| House Call | Greater than 3 hours | $600.00 |
| House Call | Greater than 2 hours | $450.00 |
| House Call | Less than 2 hours | $300.00 |
| | | |
| Comprehensive evaluation | 90 minutes | $175.00 |
| Extended establish care visit | 75 minutes | $145.00 |
| Establish care visit | 60 minutes | $115.00 |
| Complexity: 99205, 99215 | Diagnostic assessment | $105.00 |
| | | |
| Counseling | 50 minutes | $95.00 |
| Extended follow-up visit | 45 minutes | $85.00 |
| Complexity: 99204, 99214 | Diagnostic assessment | $70.00 |
| | | |
| Acute or follow-up visit | 30 minutes | $55.00 |
| Materials fee | During visit or procedure | $50.00 |
| Basic exam fee | During visit or procedure | $45.00 |
| | | |
| Complexity: 99203, 99213 | Diagnostic assessment | $35.00 |
| Brief or procedural visit | 15 minutes | $25.00 |
| Complexity: 99202, 99212 | Diagnostic assessment | $15.00 |
| Prescription fee | Less than 10 minutes | $15.00 |
| Lab fee | Less than 10 minutes | $15.00 |

# Financial Responsibility

Time spent with each patient is typically twice what any corresponding CPT (Current Procedural Terminology) code requires. The additional time is spent developing a detailed history, providing patient education, and creating individualized treatment plans.

Visits often incorporate a combination of elements and charges based on time, complexity, and any specific fees for services rendered. Payment may be made in advance or in-person at time of service by PayPal, Check, Cash, or Credit Card. A sliding scale may be considered based on need if fees are prohibitive to ongoing treatment.

Consults or visits by phone or Skype are available at the same rates, but rely on history and do not allow for physical examinations. Prescriptions and refills require a brief visit to review interactions, side effects, and instructions and include a nominal prescription fee. House calls when available are generally limited to within 30 miles of the 98101 zip code (or current location of provider) and include coordination and travel time.

I have read and understand the **Time and Fee Structure** as stated above and accept **Financial Responsibility** for services and materials rendered through the clinical care provided by Dr. Ryan Hosken.

Signature of Patient or Authorized Representative _____ Date _____

Printed Name and Relationship _____

NWNDllc Dr Ryan Hosken, ND, RN, 3231 Broadway, Everett, WA 98201, Phone: 206-954-4324

# Patient Prescription Agreement

By accepting this prescription of antibiotics I am agreeing to complete the entire course. I agree that I will **not** save any of this medication for later **nor** will I stop taking this prescription once my symptoms improve. Even though my symptoms may improve, I may still have an infection that could come back stronger if I stop early. Therefore, it is important to complete the entire course as scheduled.

I will **only** stop taking this prescription (1) if a licensed health care provider changes my prescription based on new clinical information or lab work or (2) if I develop new unexplainable symptoms such as a rash, itching, or pain.

If any new symptoms occur, I agree to seek professional medical help **immediately** as these could be signs of a life-threatening reaction. I will also seek medical help if my original symptoms do not improve following this course of antibiotics.

Printed Name: _____

Signature: _____

Date: _____ Dx: _____

Rx: _____

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# Patient Refill Agreement

By accepting this refill prescription I confirm that I am **not** allergic to this medication. As a refill and **not** a new medication, I understand why I am taking it, when to take it, how much of it to take, how often I need to take it, and how to store it safely.

I agree to call a licensed healthcare provider or pharmacist (1) if I have any questions about this medication, (2) if I develop any new symptoms while taking it, or (3) if I might want to ask about changing this medication. Any new symptoms **may** or **may not** be related to this medication.

If any new symptoms occur, such as a rash, itching, or pain, I agree to seek professional medical help **immediately** as these could be signs of a life-threatening reaction. I will also seek medical help if my original symptoms return or fail to improve with this medication. Refilled prescriptions should be reviewed by your primary care provider, as soon as possible.

Printed Name: _____

Signature: _____

Date: _____ Dx: _____

Rx: _____

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**Protection of Your Health Information and Privacy**

Dear Valued Patient,

This notice describes my office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect, I may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

***Safeguards in place at this office include:***

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

***Types of information that I gather and use:***

In administering your health care, I gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp, and other third part administrators (*e.g.* requests for medical records, claim payment information).

I value our relationship, and respect your right to privacy. If you have questions about privacy guidelines, please call during regular business hours.

***Yours truly,***

***Ryan Hosken, ND, RN***

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### HIPAA Consent Form

I consent to the use or disclosure of my identifiable health information by Ryan Hosken, ND, RN for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Dr. Hosken is not required to agree to the restrictions that I may request. However, if he agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time except to the extent that Dr. Hosken has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Dr. Hosken's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and with respect to my identifiable health information.

Ryan Hosken, ND, RN reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by calling or requesting the most current notice during any office visit.

Signature of Patient or Authorized Representative _____ Date _____

Printed Name and Relationship _____