

**Intake Form**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

If child is being seen, Name of Parent/Guardian: \_\_\_\_\_

How did you learn of Vital Healthcare LLC or Dr. Griffith?  
\_\_\_\_\_

**Present Health Concerns**

Please briefly list your health concerns in order of priority, including date of onset, progression, severity of symptoms and treatments already tried.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

What do you believe is causing your most important health concerns? \_\_\_\_\_  
\_\_\_\_\_

What goals do you have for your visit today? \_\_\_\_\_  
\_\_\_\_\_

**Healthcare Practitioners:** Please list your current medical practitioners with their contact information.

	Practitioner's Name	Office Name	City	Phone
Primary Care				
OB/Gyn				
Specialist				
Therapist				
Other				
Pharmacy				

**Allergies:** Please list and describe any severe allergies (medications, stings, foods, etc.):  
\_\_\_\_\_  
\_\_\_\_\_

**Social History:**

Please circle the most appropriate: Single Married Divorced Widowed Significant Other

Do you have any children? Y N Please list their age(s) \_\_\_\_\_

Occupation(s)/School: \_\_\_\_\_ Hours per week: \_\_\_\_\_

**Environmental Health History:**

Any known exposures to toxic chemicals? Y N If yes please specify:  
\_\_\_\_\_  
\_\_\_\_\_

Are you or your partner currently planning a future pregnancy? Y N

Are you interested in pursuing Pollutant Testing and Cleansing? Y N

**Personal and Family Medical History:**

	<input checked="" type="checkbox"/>	RELATIONSHIP	DATE Past/Current		<input checked="" type="checkbox"/>	RELATIONSHIP	DATE Past/Current
Alcoholism/ Drug Abuse				Glaucoma			
Allergies				Headaches			
Alzheimer's Disease				Heart Disease			
Anemia				Hepatitis or HIV			
Anxiety				High Blood Pressure			
Arthritis				High Cholesterol			
Asthma				Inflammatory Bowel Disease			
Autoimmune Disease				Kidney Disease			
Bleeding Disorder				Liver or gall bladder disease			
Cancer Type: _____				Mental Illness Type: _____			
Depression				Osteoporosis			
Diabetes				Parkinson's Disease			
Eczema				Stroke			
Epilepsy				Thyroid Disorder			
Gastrointestinal Disease				Vascular Disease			

**Personal Medical History:** Please list date or age and provide description:

Childhood Illness

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Serious Illnesses and Injuries

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Surgeries

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Hospitalizations

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Date of last physical / annual exam \_\_\_\_\_ Date of last blood tests or images (X-rays...  
etc.) \_\_\_\_\_

Please list any recent labs, images, vaccinations you have received:

Any abnormalities?

**Lifestyle and Personal Habits:**

Circle substances you use regularly: Tobacco                  Coffee/black tea/soda                  Alcohol

Recreational Drugs                  Pain relievers                  Antacids                  Laxatives                  Appetite suppressants

Anything you do habitually that negatively impacts you health? Please describe:

\_\_\_\_\_

Specific food cravings:

\_\_\_\_\_

Please describe any particular diet regimens or restrictions: \_\_\_\_\_

\_\_\_\_\_

Do you exercise regularly? Y N    What type and How Often?

Do you believe stress has a major impact on your personal well being? Y N

What are your greatest stressors in life?

\_\_\_\_\_

On a scale of 1-10 (10 being best), how do you rate the quality of your sleep? \_\_\_\_\_

How do you cope with stress?

\_\_\_\_\_

What are your greatest joys in life?

\_\_\_\_\_

How much water do you drink per day?

\_\_\_\_\_

Rate your eating habits currently from 1-10 (10 being best)\_\_\_\_\_    Do you know how to eat well? Y N

Do you have interest in Intravenous Nutrient / Vitamin infusions? Y N

Do you have satisfying, meaningful, and positive relationships with friends, family, or loved ones? Y N

Do you have a spiritual practice? Y N    Do you have faith that you can heal and be well? Y N

Do you have interest in Energetic and Intuitive Healing Arts? Y N

What qualities most define a good Dr. for you?

\_\_\_\_\_

What is your level of commitment towards your health on a scale from 1 to 10? \_\_\_\_\_

Thanks for choosing Vital Healthcare and Dr. Griffith!



**Vital Healthcare LLC**  
**Consent for Treatment**

The naturopathic doctor may perform, order, or prescribe any of the following procedures and therapies as necessary to properly evaluate, diagnose and treat your health concerns:

**General Diagnostic Procedures:** including, but not limited to, physical exams, diagnostic imaging (X-rays, ultrasound, etc.), venipuncture, pap smears and other specimen collection for diagnostic labwork.

**Psychological and Lifestyle Counseling:** promotion of wellness using recommendations for exercise, sleep, stress management and balancing of work and social activities.

**Botanical and Homeopathic Medicines:** use of therapeutic plant substances in oral and topical forms and homeopathic remedies (dilute quantities of naturally occurring plant, mineral and animal substances) in oral and topical forms.

**Dietary Advice and Therapeutic Nutrition:** use of foods, diet plans or nutritional supplements. May include intramuscular nutrient injections and intravenous nutrient therapy.

**Soft Tissue and Osseous Manipulation:** use of massage, neuromuscular techniques, muscle energy stretching, or visceral manipulation, and manipulations of the extremities and spine.

**Prescription Items:** pharmaceutical medications contained within the Washington naturopathic formulary, contraceptives, and immunizations.

***Potential Risks:*** including, but not limited to, pain, discomfort, blistering, discolorations, infection, burns, fainting or tissue injury from needle insertions, topical procedures, heat or frictional therapies; adverse reactions to prescribed herbs or supplements such as allergic reaction, arrhythmia, headache, nausea; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

***Potential benefits:*** including, but not limited to, 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 and management of disease.

***Notice to Pregnant Women:*** All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy.

I hereby authorize the naturopathic doctors at Vital Healthcare LLC to perform, order, or prescribe the above procedures and therapies as necessary to facilitate my diagnosis and treatment. I understand that I may ask questions regarding my individual 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 that no guarantees have been given to me by the naturopathic doctors at Vital Healthcare LLC.

<b>Patient's Name (PRINT)</b>	<b>Patient's Guardian/Representative</b>	
<b>Patient' signature</b>	<b>Date</b>	<b>Guardian's signature</b>

**PATIENT NOTICE OF PRIVACY POLICY**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED OR DISCLOSED, AND HOW YOU CAN ACCESS YOUR MEDICAL INFORMATION.**

**Patient Rights and Uses and Disclosures of Health Information:**

During the course of your care with Thomas A. Griffith ND, we may need to use or disclose personal and healthrelated information in instances such as the following:

- Personal health information and clinical records may be disclosed to another health care provider or hospital.
- Health care and billing records may be disclosed to another party, such as an insurance carriers, if they are or may be responsible for payment of your services.
- Name, address, phone number, and health care records may be used to contact you regarding appointment reminders or your care. (If you are not at home to receive an appointment reminder, we may leave a message. **You have the right to refuse authorization to contact you**). Under federal law, we also may disclose your health information without your consent under the following circumstances:
  - In providing health care services based on the orders of another health care provider.
  - In an emergency.
  - If we are required by law to provide care and are unable to obtain your consent.
  - If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.
  - If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. You have the right to inspect and/or copy your health information. You have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided in writing.

**Physician Legal Duties:**

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible.

**Complaints and Questions:**

If you have a complaint regarding our privacy notice, our privacy practices or if you would like more detailed information, please contact: Vital Healthcare LLC at 360-455-8281.

My signature acknowledges that I have received a copy of this notice.

\_\_\_\_\_

Patient Name (Printed please) Signature Date \_\_\_\_\_

*If you are a minor, or if you are being represented by another party, your representative signs below:*

\_\_\_\_\_

Personal Representative Printed Personal Representative Signature Date

# Vital Healthcare LLC.

## **Insurance & Financial Policies:**

Thank you for choosing us for your health care. If you have medical insurance that covers our services, we are happy to assist you in submitting your insurance claims. If you do not, payment is expected at the time of service. Co-pay or co-insurance is also due at the time of service.

### **Insurance:**

If we are not able to verify coverage, payment in full is expected at the first visit. If your insurance company remits payment you will be reimbursed. In some cases, care agreed to be medically indicated by the physician and the patient may not be covered by insurance (for example: IV therapy, lab tests, supplements, pre-existing conditions, etc.) Please check with your insurance company to find out if there are any exclusions in your policy. **It is important to understand that a verbal confirmation of coverage over the phone from the insurance company does not guarantee payment.** As is not uncommon for an insurance company to misquote a policy, we recommend reviewing your policy to confirm that the information we received is correct. It is the patient's responsibility to follow up if a claim is not paid. By signing this agreement you agree to pay your co-pay or co-insurance and any fees that your insurance company does not cover.

### **Supplements:**

Most insurance companies do not cover supplements. Payment in full is expected at time of purchase. We are prohibited from accepting returns once a safety seal has been broken. There is no requirement to purchase recommended supplements from our office; there are several local stores that may carry similar products and we would be glad to assist you to obtain suitable options.

### **Late Cancellation/Missed Appointments:**

As a courtesy to other patients requiring services, we request that you provide notice of cancellation 24 hours in advance of your appointment. **Patients who do not give 24 hour notice for a missed appointment will be charged a fee of \$100 for missing a New Patient Office Visit and \$75 for missing a follow up visit.** After two missed appointments, you will be charged for the entire time or materials reserved for you on the schedule. Please note, we attempt to contact you for an appointment reminder as a courtesy. If you do not receive a reminder call prior to your appointment, the missed appointment fee still applies.

### **Methods of Payment:**

We accept cash, checks, debit, Visa, MasterCard. There is a \$25.00 fee for returned checks to cover bank fees. If you have questions about any of the above please contact the office. We appreciate that you have chosen us for your health care and are glad to be of service to you.

### **Authorizations:**

I have read the above information and agree regardless of my insurance status to be responsible for the balance of my account. I agree to pay for all services rendered not covered by my insurance and to notify this office should there be any change in my insurance coverage.

AND

I authorize the release of any medical or other information necessary to process any claims.

AND

I authorize payment of medical benefits to Thomas A. Griffith ND for all services rendered.

### **Patient's or Authorized Person's Signature:**

Name (please print): \_\_\_\_\_

Signature: Date: \_\_\_\_\_

Vital Healthcare LLC

**Thomas Griffith, ND**  
**3525 Ensign Rd. NE Suite N (Beyond Medicine)**  
**Olympia, Wa. 98506**  
**(360) 455-8281**

**PATIENT REGISTRATION**  
**Please fill out completely**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
SSN: \_\_\_\_\_ Gender: ( )M ( )F  
Home ph: \_\_\_\_\_ Mobile ph: \_\_\_\_\_ email: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work ph: \_\_\_\_\_  
Employment: ( )Employed ( )F/T Student ( )P/T Student ( )Retired ( )Other  
Marital Status: ( )Single ( )Married ( )Divorced ( )Widowed ( )Dependant ( )Partners

Responsible Party:  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_

In emergency contact: Phone: ( )

**PRIMARY INSURANCE**

Insurance Company Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Claims Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security number: \_\_\_\_\_  
Subscribers Address(if different than above):  
City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Relationship to you: ( )Self ( )Spouse ( )Dependant ( )Other  
I.D. # as shown on card: \_\_\_\_\_ Group #: \_\_\_\_\_

**SECONDARY INSURANCE**

Employer of insured: \_\_\_\_\_ Phone: \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Claims Address: \_\_\_\_\_ City: \_\_\_\_\_  
ST: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
SSN: \_\_\_\_\_  
Subscribers Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Relationship to you: ( )Self ( )Spouse ( )Dependant ( )Other  
I.D. # as shown on card: \_\_\_\_\_ Group #: \_\_\_\_\_

**Signature Date**

*I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assessed a fee. 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.*

Is this visit injury related? ( )Y ( )N Work related? ( )Y ( )N Auto accident? ( )Y ( )N State: \_\_\_\_\_