Dr. Thomas Griffith | 2584 R W Johnson Blvd Suite 102| Tumwater WA 98512
Ph: 360-455-8281 | Fx: 888-464-1120 | frontdesk@docgriffith.com
Open by appointment only | Closed Wednesdays

Thank you for scheduling an appointment with Dr. Thomas Griffith. Patients being seen in our clinic are required to wear a mask. There are no exceptions.

24 HOUR NOTICE APPOINTMENT CANCELLATION/RESCHEDULE POLICY

To avoid a $100 rescheduling fee, our office requires a 24-hour notice if you need to cancel or modify your appointment. This applies to in-person and virtual appointments.

In-person Appointment - Visit the "for patients" tab at docgriffith.com to access the required new patient forms. Plan to arrive 15 minutes prior to your scheduled appointment time with your new patient forms filled out. Our clinic is located inside of the Mottman Plaza on the corner of Mottman Rd SW and R W Johnson Blvd SW, and near South Puget Sound Community College. Look for the sign with the big red apple located on our building.

Virtual Appointment - Visit the "for patients" tab at docgriffith.com to access the required new patient forms. Your completed forms must be received at least one day prior to your scheduled appointment, and we will email you to let you know they've been received. A link to your virtual meeting with Dr. Griffith will be emailed to you a few hours before your appointment.

Bring with you (in-person) or send a copy (virtual):

- Completed New Patient Forms
- Health Insurance Card
- Photo ID
- Any pertinent labs, reports, supplements, and prescriptions that you would like to go over with the doctor.

Email: frontdesk@docgriffith.com
Fax: (888) 464-1120

NEW PATIENT REGISTRATION FORMS

First Name:_____ MI:_____ Last Name: _____

Mailing Address:_____ Email:_____

City:_____ State:_____ Zip: _____Home#_____

Gender at Birth: ☐ M ☐ F Date of Birth: ____/____/____ Age: _____Cell#_____

Employer:_____Work# _____

Occupation/Vocation:_____ Children? ☐ No ☐ Yes, Age(s)_____

Domestic Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

PRIMARY INSURANCE

Insurance Company Name:_____ Phone # _____

I.D. # as shown on card: _____ Group # _____

Subscriber's Name: _____ Date of Birth: _____/_____/_____

Relationship to you: ☐ Self ☐ Spouse ☐ Dependent ☐ Parent ☐ Other

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EMERGENCY CONTACT

(You authorize that we may contact below person in case of an emergency.)

Name: _____Relation: _____ Phone: _____

Please READ CAREFULLY, initial each and sign below.

____ *I understand that if I fail to cancel or change an appointment with at least a 24 hours notice, I will need to pay a* ***$100 missed appointment fee before my visit is rescheduled.***

____ *I understand that balances left on my account over 90 days may be sent to collections.*

____ *I understand that all co-pays, co-insurance and deductible amounts due are due at the time of service.*

____*I understand that Vital HealthCare/Dr. Griffith does not bill Medicare or offer secondary insurance claim billing.*

____ *I understand that if I fail to provide complete and accurate insurance billing information at the time of service, I may be billed and held responsible for all charges.*

Signature: _____ **Date:** _____

How did you learn of Dr. Griffith and Vital HealthCare? _____

Which of the following are you interested in learning more about?

☐ IV Vitamin Therapy ☐ Heavy Metal Testing ☐ Headache Treatment ☐ Pain Treatment

HEALTHCARE PRACTITIONERS: Please list your current medical practitioners with their contact information.

	Practitioner's Name	Office Name	City	Phone
Primary Care				
Ob/Gyn				
Specialist				
Specialist				
Specialist				

TOP 4 HEALTH CONCERNS:

COMPLAINTS / SYMPTOMS	DATE OF ONSET	SEVERITY SCALE 1-10

How many hours of sleep do you get each night on average? _____ Do you wake rested? ☐ No ☐ Yes

What are your greatest joys in life? _____

Do you feel you have adequate social support (family, friends, counselor, etc.)? ☐ No ☐ Yes

Do you have any special dietary restrictions? ☐ No ☐ Yes _____

_____

How many servings of fruit do you eat daily? _____ Vegetables? _____ How much water daily? _____

List 5 daily dietary staples: _____

_____

Do you exercise regularly? ☐ No ☐ Yes, type of exercise(s) and frequency_____

_____

What qualities define a good doctor for you? _____

What is your level of commitment towards your health on a scale of 1 – 10? _____

Pharmacy Name: _____ **Location:** _____

(Please note - all prescription renewals require an office visit every 6 months)

CURRENT PRESCRIPTIONS & OVER-THE COUNTER MEDICATION

Start Date	Rx Name	Reason for RX	Dose	Frequency

CURRENT VITAMINS & SUPPLEMENTS

Start Date	Name	Reason	Dose	Frequency

DRUG ALLERGIES: **REACTION:**

HOSPITALIZATION, SURGERIES, SERIOUS INJURIES

TYPE/REASON:	DATE:

Are you over 50 Years old? If yes, please check the screening tests you may need:

☐ Skin Cancer Exam ☐ Colonoscopy ☐ Mammogram ☐ Bone Density ☐ Prostate ☐ Labs

Female Patients: Date of last pelvic exam / Pap smear ____/_____ Results: ☐ Normal ☐ Abnormal

LIFESTYLE AND PERSONAL HABITS

TYPE:	PRESENT USE:	PAST USE:	DATES: Month/Year	AMOUNT	FREQUENCY
Tobacco			____/___ **to** ____/____		
Vaping			____/___ **to** ____/____		
Alcohol			____/___ **to** ____/____		
Recreational Drugs			____/___ **to** ____/____		
Pain Relievers			____/___ **to** ____/____		
Coffee/Black Tea			____/___ **to** ____/____		
Soda/Energy Drinks			____/___ **to** ____/____		
Antacids			____/___ **to** ____/____		
Laxatives			____/___ **to** ____/____		
Other:			____/___ **to** ____/____		

Place a "C" for current or "P" for past in the box as it applies to you or to your family members.

MEDICAL HISTORY	Self	Mother	Father	Siblings	Grandparent
Alcohol Abuse					
Allergies/Asthma					
Anemia					
Autoimmune Disease					
Brain/Neurologic Disease					
Cancer					
Diabetes Type 1 or 2					
Dermatological Conditions					
Eczema					
Gastrointestinal Disease					
Glaucoma					
Headaches/Migraines					
Hepatitis					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Kidney Disease					
Mental Illness					
Menopausal Symptoms					
Osteoporosis					
Sleep Problems					
Substance Abuse					
Tuberculosis					
Vascular Disease/Stroke/Clots					

Mother is: Living _____ Age_____ Mother is: Deceased _____ Age_____

Father is: Living _____ Age_____ Father is: Deceased _____ Age_____

CONSENT FOR TREAMENT

General Diagnostic Procedures, Psychological and Lifestyle Counseling, Nutrient and Botanical Medicines in all forms of administration, Dietary Advice and Therapeutic Nutrition, Soft Tissue and Joint Manipulation, Prescription Medication as contained within the Naturopathic Formulary of Washington State in all forms of administration.

Potential Risks: Including, but not limited to, pain, infection, allergy, fainting, nerve damage, death or tissue injury from needle intramuscular, subcutaneous, intravenous insertions, topical procedures, biopsies, heat / friction / physio-therapy application; adverse reactions to prescriptions, herbs or nutrients including allergy, cardiovascular events, kidney or liver injury, headache, nausea and vomiting; soft tissue , nerve, joint or bone injury from physical manipulations; and aggravation of existing symptoms or conditions.

Notice to Pregnant Women: All females knowing or suspecting pregnancy must alert the doctor since some therapies may present a risk to the pregnancy.

I hereby authorize the providers at Vital HealthCare LLC to perform, order, and prescribe the procedures, therapies and tests listed below 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 providers at Vital HealthCare LLC.

PATIENT NOTICE OF PRIVACY POLICY

During your course of care with Vital HealthCare we may need to disclose personal and health information in instances such as the following:

--Personal, Health, Billing and clinical records may be disclosed to another health care provider, hospital, or insurance carrier.

--Your records may be used to contact you regarding appointment reminders or care.

Under federal law, your records may be disclosed under the following circumstances:

--In providing services based on the orders of another provider.

--In an emergency.

--If we are required by law to provide care and are unable to obtain your consent.

--If there are substantial communication barriers but in our professional judgement, we believe you intend for us to provide care.

--By order of the courts or other appropriate agency.

Use or disclosure of your records, other than as outlined above, will only occur upon your written authorization.

INSURANCE AND FINANCIAL POLICY

If your insurance covers our services, we will submit claims on your behalf. If you are not covered, payment is expected at the time of service or in the form of a deposit for new patients. Co-payment or co-insurance, and payment for non-covered treatments are also due at time of service. If payment by check is cancelled by your bank, a fee will be added to your balance.

Supplements: Insurance does not cover supplements. Payment is expected at time of purchase. We do not return items if the safety seal has been broken.

It is important to understand your policy and its coverage and limitations. VHC cannot guarantee coverage and it is a patient's responsibility to know the details of their policy. We recommend reviewing the policy thoroughly and calling your insurance company with any questions. It is the patient's responsibility to follow up if a claim is not paid. By signing this agreement, you agree to pay for any fees that are not covered by your insurance company.

COMMUNICATIONS POLICY

By signing, you are agreeing to allowing our office to contact you and to relay communication to you via email, phone, fax, text, and video. At Vital HealthCare, we are constantly upgrading communication privacy, but cannot guarantee security of all communications.

I have read and understand the Vital HealthCare Consent for Treatment, Privacy Policies, Insurance and Financial Policy, and Communication Policy. I have been given opportunity to ask questions and get clarification on these policies. By signing this document, I am acknowledging receipt and agreement to these notices.

PATIENT PRINT NAME	**PATIENT SIGNATURE**	**DATE**

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

REP PRINT NAME	REP SIGNATURE	DATE