Lung Screening Questions

Do you smoke? ___Yes ____ No ____ Never

If **Yes** :

How many packs per day do you smoke? _____

How many years have you smoked? _____

If **No**:

Have you ever smoked? _____ Yes _____ No

How many packs per day did you smoke? _____

How many years did you smoke? _____

How many years ago did you quit? _____

If **No/Never**:

Have you been exposed to second-hand smoke?

____Yes ____No ____Never

Name: _____ DOB: _____

Dr. Initials: _____ Date: _____

Print Name: _____ DOB:_____

Yellowstone Naturopathic Clinic

As a courtesy, we are now sending appointment reminders through text and/or email 4 days prior to your appointment as well as the day of.

Email: _____

Cell Phone:_____

_____ Opt me out of text communication. (Appointment reminders and continuing care)

_____Opt me out of email communication. (Customer promotions, appointment reminders, continuing care, birthday message, thank you message)

_____Opt me out of Phone Call reminders. (Appointment reminders)

Signature: _____ Date:_____

Yellowstone Naturopathic Clinic - 720 N 30th St. - Billings, MT 59101 (406-259-5096)

Name _____ Doctor _____ Date _____

Please list any additions to your **current** Medications and Supplements below.

(Include all prescribed and over-the-counter items.)

Medication/Supplement	Dosage	Directions

Any Drug or Other Allergies? No _____ Yes (please list) _____, _____

_____, _____, _____, _____

Are you having difficulty in your ability to perform routine daily living activities, or has there been a change since your last visit? No _____ Yes (please explain) _____

_____

Have you had any recent x-rays, imaging or scans? No ____ Yes (please list) _____

Do you use tobacco? No ____ Yes (How much?) _____

Would you like help with quitting? No _____ Yes _____

Do you have concerns about safety in your home/falls? No _____ Yes _____

Do you have concerns about physical or emotional abuse? No _____ Yes _____ (optional)

(You may discuss the above with the doctor instead of indicating your concern(s) on this form.)

Surgical History:_____

Last Mammogram:_____ **Last Pap**_____ **Last GYN exam**_____

Last Colonoscopy:_____ **Last DRE/PSA**_____

FAMILY MEDICAL HISTORY

Please list ages, health problems and, if deceased, cause of death (only include blood relatives)

Relative	Age	(L)iving or (D)eceased	Cause of Death	Health Concerns: *heart disease, diabetes, cancer, thyroid, depression/anxiety, etc.*
Mother				
Father				
Brothers				
Sisters				
Children				
Grandparents:				
Mother's mom				
Mother's dad				
Father's mom				
Father's dad				

YELLOWSTONE NATUROPATHIC CLINIC
720 N 30th St Billings, MT 59101 406-259-5096 Fax: 406-545-0044

Patient's **LEGAL** Name _____ aka/Nickname _____ Date _____

Date of Birth _____ Soc. Sec. #_____ Male ___ Female ___ Marital Status _____

Primary Contact Phone Number _____ *(circle one)* Landline or Mobile

→Can we leave messages with detailed medical information at your primary contact phone number?

(mark one) Yes _____ *No _____

**If "No", to remain HIPAA Compliant, we will be required to leave a vague message asking you to return our call to receive any medical information.*

Residence Address (physical address) _____

City _____ State _____ Zip Code _____

Mailing Address (if different) _____

City _____ State _____ Zip Code _____

How long at present address? _____

If patient is a minor, parent/guardian's name _____

Employer _____ Work Phone Number _____

City _____ State _____ Zip Code _____

Responsible Party for Account _____

Address (if different from above) _____

City _____ State _____ Zip Code _____

In Case of Emergency, Whom Should We Notify? _____

Address _____ Relationship _____

Primary Contact Number _____ Alternate Phone Number _____

How did you learn of our Clinic?

Personal Referral (please tell us who so we may thank them) _____

Doctor Referral (which physician?) _____

Gazette / Simply Family / T.V. / Rimrock Neighbors / Social Media (circle one)

Other (please describe) _____

Payment is due at the time of service as we do **NOT** bill insurance.

We accept cash, check and all major credit cards.

Yellowstone Naturopathic Clinic will verify this contact information whenever you come in for an appointment. However, if your circumstances change, it is your responsibility to give us your new contact information.

Signature _____ Date _____

Rev. 04/17

Yellowstone Naturopathic Clinic Policy

720 North 30th Street
Billings, MT 59101
(406) 259-5096 Phone
(406) 545-0044 Fax

Appointments:
Your appointment time has been reserved for you. If you cannot make this appointment, please inform us as soon as possible so that we may give this time to another patient. FAILURE TO PROVIDE US WITH **24** HOURS NOTICE OF APPOINTMENT CANCELLATION WILL RESULT IN A CHARGE TO YOUR ACCOUNT.

Your first visit will be scheduled for 90 minutes. The charge is $290.00**. During this time your doctor will talk with you in depth about your health concerns, pertinent past medical history, etc. Medical records of previous care by other physicians may be requested at this time. Your doctor may also discuss and arrange for laboratory testing to be done before your next visit. Not all lab tests require fasting. Please remember, there is no need to fast unless specifically told to do so.

The second appointment is scheduled for 90 minutes and costs $290.00**. This appointment is typically 2 – 3 weeks later and includes a comprehensive physical examination, review of laboratory results and an individual treatment plan designed to start you on the road to better health. If you have a health problem of an acute nature, we will address that problem while keeping our primary focus on uncovering and resolving the underlying cause. The charges for the two initial visits do not include any dispensary items that may be prescribed for you.

****Fees, Insurance and Accounts Receivable:**
Subsequent visits are scheduled as brief, routine or extended and are billed at $113, $158 and $209. **We expect payment at the time of visit unless prior arrangements have been made.** Please note that Yellowstone Naturopathic Clinic accepts VISA, Discover, MasterCard and American Express. If you have insurance coverage, we will provide you with a form that includes all the appropriate procedure and diagnostic codes your insurance company will need to process your claim. Unfortunately, Medicare and Medicaid do not cover naturopathic care. **We are NOT in-network providers with any insurance company, so there is no guarantee that your insurance plan will cover these charges.** Numerous health insurance companies do cover naturopathic doctors as primary care physicians so we encourage you to check with your insurance company to verify if these services will be covered under your plan.

Phone Consultations and Questions:
Please feel free to discuss with us any questions you may have. During all phases of your care, it is important that you fully understand your treatment program. If you have any questions please address them to the Yellowstone Naturopathic Clinic staff. The staff will relay your questions promptly to the appropriate doctor. The doctors maintain full schedules and may not be able to answer your questions directly or immediately. Either the doctor or a staff member will get back to you as soon as possible. Should you have a number of questions regarding your treatment or progress, we suggest that you make an appointment so that we may properly meet your needs. **Doctor's telephone consultations that extend beyond 5 minutes will be billed to your account.** PLEASE NOTE THAT TELEPHONE CONSULTATIONS ARE NOT USUALLY COVERED BY MOST INSURANCE COMPANIES.

Emergencies:
One of our doctors is on-call 24 hours a day. Calls to the Clinic at 259-5096, outside regular business hours, are automatically transferred to our answering service. The service will then contact the doctor to return your call. For medical emergencies, please call 911.

Acknowledgements:
We hope that you will find your visit with us pleasant as well as beneficial. Our goal is to help you in building better health.

Signing this form acknowledges that you understand and accept the policies of the Yellowstone Naturopathic Clinic.
****All fees subject to change****

Signed _____ Date: _____

Rev. 07/17

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request or refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliant Officer. You have the right to review our privacy notice, to request restrictions and to revoke consent in writing after you have reviewed our privacy notice.

Patient's Representative(s): (the following must be filled out, even if the answer is none)
This person is a family member or friend who may call our office on your behalf. Unless their name is listed below, we will not be able to speak with them about your medical concerns.

*** I hereby authorize the following individuals to have access to my healthcare information:**

_____, Relationship to Patient _____
_____, Relationship to Patient _____
_____, Relationship to Patient _____

PHOTOGRAPH

I authorize YNC to take a photograph of me for my file. ☐ **Yes** ☐ **No**

A photo helps us improve medical care. Photos prevent identification errors and (in conjunction with written records) prompt our physicians in recalling your needs, concerns and medical issues. This image will not be shared outside of Yellowstone Naturopathic Clinic. The confidentiality of this image will be maintained in accordance with HIPPA regulations.

TERM

This consent will be in effect for one year from the date signed.

Printed Name of Patient _____ **Date** _____

Patient or Responsible Party Signature _____

Responsible Party's Relationship to Patient _____

Witness _____ **Date** _____

** *If you would like a copy of this form, once signed, please ask the receptionist* **

Patient Compliance Assurance Notification

To our valued families and patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to insure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also know that we are not perfect! Because of this fact our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. Thank you, for being one of our highly valued patients!