PATIENT INFORMATION

PATIENT NAME _____ DATE_____ PHONE H (_____)_____ WK (_____)_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

BIRTHDATE_____ AGE_____ ☐ MALE ☐ FEMALE ☐ UNDER 18 ☐ 65 OR OLDER

OCCUPATION_____ EMPLOYER_____

IF UNDER 18, MOTHER'S NAME _____ PHONE # (IF DIFFERENT) (_____)_____

FATHER'S NAME _____ PHONE # (IF DIFFERENT) (_____)_____

PERSON TO CONTACT IN CASE OF EMERGENCY_____ PHONE# (_____)_____ RELATIONSHIP_____

Financially Responsible Person, (if different than patient)

Name_____

Address_____ City_____ State_____ Zip_____

Relationship to Patient_____ Hm Phone# (_____)_____ Wk Phone# (_____)_____

Financial Policy

Payment
You are responsible for all charges incurred while under treatment. Full payment is expected at the time services are rendered. We accept cash, check, Visa or Master Card in the office or over the phone. After 60 days a 1.5% monthly service charge will be applied to your account.

Insurance
We do not bill insurance companies. We can provide you with super bills that you mail into your insurance company. You are responsible for all charges.

Seniors
An office visit discount will be given to our patients age 65 or over. Medicare/Medicaid will not cover Naturopathic services.

Agreement: I understand and agree to the above financial policy. I will abide by its terms.

Signature: _____ Date: _____/_____/_____

Consent to Use Electrodiagnostic Methods

I understand that Dr. Robert Jangaard is a Naturopathic Physician licensed in the State of Washington. That he has extensive training in the use of Electrodiagnostic Testing Instruments and is using the data from these tests to investigate a functional assessment of my condition, (not a pathological diagnosis). That the collection of this data may be used in research being conducted by the AANP (American Association of Naturopathic Physicians) position paper titled Electrodiagnosis in Naturopathic Practice under the bylaws of the AANP.

Signature: _____ Date: _____/_____/_____