Adult Medical History, Informed Consent, Office Policies

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Please complete this Medical History Form - following the directions on the webpage - and email it as an attachment, together with a recent photo of the patient, to your doctor. NOTE: Your typed name will serve as your signature.
* Dr. Robert Ullman (drbobullman@gmail.com)
* Dr. Judyth Reichenberg-Ullman (drreichenberg@gmail.com)

Personal Information

Name		Date of Birth	
Address		City	
State	Zip	Country	
E-mail			
Phone: Home	Cell	Skype	
Occupation		Spouse/Significant Other	

In case of emergency, notify

How did you hear about us?

Medical History

Your main health concerns:

Significant life traumas or stresses:

Healthy Homeopathy

Significant past health problems, accidents, hospitalizations or surgeries? (include dates)

Family history of serious illnesses? (Include condition and which family member)

Current medications and nutritional supplements (include dosages):

Primary care physician:

Any upcoming diagnostic testing or medical or dental treatment?

Informed Consent to Homeopathic and Naturopathic Treatment and Office Policies

I (name) _____ consent to be treated

by Dr. _____, a licensed naturopathic physician in the State of Washington.

Description of treatment: Homeopathic medicine uses dilute, natural substances to treat the whole person. Naturopathic medicine utilizes various natural therapies including herbs, vitamins and minerals, nutritional recommendations, manipulation, and psychological counseling. Although many scientific studies and years of clinical experience have shown these procedures to be safe and effective, they are still recognized by some individuals and groups as "experimental." I recognize the potential risks and benefits of homeopathic and naturopathic medicine.

Potential risks: Adverse reactions to homeopathic medicines, herbs, vitamins, minerals, nutritional recommendations, manipulation, or other prescribed treatments.

Potential benefits: Improved health that may lead to prevention or relief of symptoms and elimination of problems.

Release: Fully understanding the above-described information and potential risks, I voluntarily consent to treatment, realizing that, as with any medical treatment, no guarantees are possible and none have been given to me by my doctor or his/her staff regarding any cure or improvement in my condition. I hereby release Dr. Ullman's and Dr. Reichenberg-Ullman's clinic, staff, or on-call physician (in case of emergencies) from any and all liability that may arise as a result of my diagnosis and/or treatment. I understand that any of my questions regarding treatment will be answered by the doctor and that I am free to withdraw my consent and to discontinue treatment at any time.

Medical records: I authorize the utilization of clinical or other information contained in my medical records for research, teaching, or publication in an article or book, so long as my identity is not disclosed. Information regarding my case may be shared with other health professionals or with attorneys, with my permission.

Payment: I have been informed about the doctors' fees and acknowledge that I am directly responsible for payment of all charges incurred while I under the care of Drs. Ullman or Reichenberg-Ullman. I understand that all payments for appointments will be paid at the end of each appointment and that remedies, supplements, and books must be paid in full at the time they are prescribed or ordered. I agree to provide and update current credit card information for payment or to make other arrangements if I do not have one. I agree to pay for any costs of collection and/or attorney fees or costs incurred by any delinquent unpaid balances on my or my child's account.
Insurance: I will pay all fees directly to The Northwest Center for Homeopathic Medicine (NCHM) at the time of each visit and, if appropriate. I may seek reimbursement from my insurance provider. I am aware that this is a cash practice, that the doctors do not contract with any insurance providers, and that telephone consultations may not be covered by insurance.

Cancellations and Missed Appointments: Email reminders of my appointments are only a courtesy. I am responsible for any appointments that I have scheduled, whether or not I receive an email reminder. If I must cancel my first or any other scheduled appointment, I will email nchmclinic@gmail.com . If I do not use email, I will leave a message on the office voice mail at (425) 774-5599. Cancelling the first appointment without rescheduling will result in a $50 administrative fee. For subsequent appointments, I will notify the clinic at least 48 hours in advance. I understand that appointments cancelled between 48 and 24 hours before my scheduled appointment, except in the case of true emergencies, will be charged half the appointment fee. In the case of appointments cancelled less than 24 hours in advance, or missed appointments, I understand that I will be charged the full appointment fee.

Special Payment: If I am 65 or older, I qualify for a 10% discount on return office visits, which I will request. If I have a financial hardship, I may inquire about special arrangements prior to my appointment.

I HAVE READ AND UNDERSTAND THIS AGREEMENT AND AGREE TO ALL OF THE ABOVE PROVISIONS.

_____ _____

(Signature of patient or of person authorized to consent for patient) (Date)