Dr Kara Lolley N.D., L.A.C., P.C.

307 S 12th Avenue, Suite 20-Yakima, WA 98902

Phone: 509-759-7470 fax: 509-759-7184 - Email: yakimahealingarts@outlook.com

YAKIMA
HEALING ARTS

Confidential Health Intake Form

Name: _____Date: _____

Address: _____ City/ State: _____ Zip_____

Date of Birth: _____ Age: _____ Gender: Female _____ Male _____

Email: _____

Phone number (preferred): _____ Phone Number (Alternate): _____

Do you prefer Appointment reminders by: Text _____ Email_____ Phone call_____

Emergency Contact Name:

_____

Emergency contact Phone Number: _____ Relationship to Patient: _____

Payment policy:

Payment is required at the time of service unless other arrangements have been previously made, for your convenience, we accept cash, personal checks, Mastercard, visa debit/credit cards and HSA cards. We are currently not contracted with any insurance plans. We are happy to provide you with a coded bill, which you can submit to your insurance company. 10% of Dr Lolley's practice is pro bono or discounted, if you feel you qualify for assistance, please ask at the front desk to be added to the waiting list.

Missed Appointments:

We charge $50.00 per hour for appointments missed or canceled in less than a 24-hour notice. The office is closed on Friday, so appointments scheduled for Monday will need to be cancelled by the end of business at 3pm on Thursday. If you arrive more than 15 minutes late for your appointment with out a call, be aware your appointment may be given to another patient.

Telephone Consultation:

We are happy to answer short questions and clarify instructions from a previous visit on the phone or via email without charge. If you have a question about a new topic, please make an appointment.

In case of an emergency after normal business hours Please call 911.

I, _____ have read the above office policies and understand them.

Signature: _____Date: _____

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Notice of Privacy Practices

I keep a record of the health care services I provide you. You may ask to see and copy that record. You may also ask to correct that record. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels me to do so.

The **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Patient or Legally authorized individual signature Date Time

_____ _____

Printed Name if signed on behalf of the patient Relationship

(parent, legal guardian, representative)

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HEALING ARTS

Name: _____Date: _____

Primary Care physician: _____Phone: _____

Last Visit: _____ Last Lab's: _____

Primary Health Concerns:

_____
_____
_____
_____
_____
_____
_____

Current Medication and Supplements:

_____
_____
_____
_____
_____
_____

Surgical History:

_____
_____
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_____
_____
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_____

Trauma History:

_____
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_____
_____
_____

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Family Medical History:

_____
_____
_____
_____
_____

Known Medication Allergies:

_____
_____
_____

Known Food Allergies:

_____
_____
_____

Known Environmental Allergies:

_____
_____
_____

Exercise Habits:

_____
_____
_____

Sleep Habits:

_____
_____
_____

Other Concerns:

_____
_____
_____
_____
_____
_____

Signature: _____Date: _____