PNW SUSTAINABLE MEDICINE

Dr. Glynn believes strongly that naturopathic preventive care should not be limited to the wealthy and that **finances should never be the only barrier** to experiencing health and happiness. Through **PNW Sustainable Medicine, a 501(c)(3) federally-recognized nonprofit clinic**, Dr. Glynn can deliver high-quality holistic care at a discounted cost to those who need it most. She focuses on optimization of health, rather than solely on treating disease.

The mission of PNW Sustainable Medicine NFP is to expand access to high quality and affordable naturopathic care to underserved populations. This includes those with low income and who are first responders, military or veterans. Because our focus at PNW Sustainable Medicine NFP is treating mental health issues, learning disabilities, behavioral issues, endocrine and autoimmune conditions, these are also included in our nonprofit care model.

Dr. Glynn is not contracted with insurance companies, but strives to offer sustainable prices for each way she connects with patients. Maximum nonprofit prices for her visits are as follows:

- first visit $95
- return visit $65
    - in-person
    - telemedicine/video
    - phone consult
- email consult $45

DETERMINING ELIBILITY FOR NONPROFIT CARE

STEP 1: Are you a member of any of the following groups?

- low income (400% of federal poverty level or below for family size)
- first responders or family of first responders (including police and fire)
- veterans, active military and their families
- individuals and families living with:
    - ADHD or autism
    - depression and anxiety
    - developmental or physical disabilities
    - behavioral and learning disorders
    - sleep conditions or disorders
    - genetic conditions like Down's Syndrome
    - endocrine/metabolic or autoimmune conditions

If your answer is YES to any of the categories above, you qualify for naturopathic medical care at PNW Sustainable Medicine NFP. Congratulations! Continue to Step 2.

NOTE: Low income individuals or families can qualify for rates below the standard nonprofit visit rates. Providing income information on the application in Step 2 will help Dr. Glynn determine the best price for your income and family size.

STEP 2: Fill out the application for our clinic records, scan it (an app like Genius Scan is free and works well) and email it to Dr. Glynn. Continue to Step 3.

STEP 3: Also download, print, and complete the intake paperwork. It's on the website right under the nonprofit application button. Then scan it and email it to Dr. Glynn. She will contact you to schedule an appointment time!

PNW SUSTAINABLE MEDICINE

I am requesting status as a patient of PNW Sustainable Medicine due one or more of the following accepted reasons:

LOW INCOME

Please state your annual income: _____
Please state your family size: _____

MEDICAL DIAGNOSIS OR DISABILITY

Please explain your diagnosis:

_____

_____

FIRST RESPONDER OR FAMILY MEMBER

Police Officer Firefighter Active Military Veteran

By signing below, I certify that the above information is true to the best of my knowledge at the present time. I have also been made aware that **I will need to submit documentation yearly regarding my income, disability, or first responder status** in order to continue to receive care at PNW Sustainable Medicine.

Name: _____

Signature: _____ Date: _____

PNW SUSTAINABLE MEDICINE

Dr. Bethany Glynn

Today's Date _____

Name _____ Age _____ Birth Date _____ Sex: M F Gender : M F

Address _____ City _____ Zip Code _____ Phone (____)_____

E-mail _____ OK to leave health information on (please circle): Phone Email

Occupation: _____ Relationship Status: _____

Person to contact in case of emergency _____ Phone (____)_____

How did you hear about our clinic? (PLEASE SPECIFY) _____

I hereby authorize the undersigned physician the right to furnish medical information, if required, to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment at time of service. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable. Furthermore, any charges, fees, or court costs incurred as a result of collection efforts will be added to my account balance. I agree to pay the full fee for services to be rendered should I cancel any appointment with less than 24 hours notice. Permission is hereby given for any medical treatment and any diagnostic procedures required for my health care, or (when patient is a minor child) for the health of my minor child.

CLINIC POLICY REQUIRES PAYMENT AT THE TIME OF SERVICE

We gladly accept: Visa • MasterCard • Other Credit Cards

_____ _____ _____

Patient's Signature Parent or Guardian's Signature Date

Please explain, in detail, why you are coming to see our doctors today? What are your long term goals regarding your health and how can we help you achieve them?

_____

_____

_____

_____

_____

_____

_____

HEALTH HISTORY

Are you currently under the care of a physician? If yes, please indicate name, facility, and reason for treatment:

_____

Date of last physical exam: _____

SYMPTOMS Check (☐) symptoms you currently have or have had in the past year

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Weight gain

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea/ Vomiting
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal
- ☐ Psoriasis

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Breast Lump
- ☐ Nipple discharge
- ☐ Abnormal Pap Smear
- ☐ Painful intercourse
- ☐ Hot flashes
- ☐ Vaginal discharge
- ☐ Menstrual Cramps
- ☐ Clotting with menses
- ☐ Bleeding between periods
- ☐ Spotting
- ☐ PMS
- ☐ Currently Pregnant?
- ☐ Irregular periods

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

CONDITIONS Check (☐) conditions you have or have had in the past

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gall stones
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pancreatitis
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problems
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infection
- ☐ Venereal Disease
- ☐ Other

MEDICATIONS List those you are currently taking:	**ALLERGIES** To medications or substances:

FAMILY HISTORY Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death	Check (√) If, your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brother(s)					Cancer	
					Chemical Dependency	
					Diabetes	
Sister(s)					Heart Disease, Strokes	
					High Blood Pressure	
					Kidney Disease	

HOSPITALIZATIONS

Year	Hospital	Reason and Outcome

Serious Illness / Injuries	Date	Outcome

Have you ever had a blood transfusion? ☐Yes ☐No

If yes, please give approximate dates: _____

LIFESTYLE / ENVIRONMENT

What is your major stressor?

How do you cope with your stress?

Do you have any difficulties sleeping?

How many hours of sleep do you get each night?

How do you relax?

Any Hobbies?

Do you exercise regularly? Please describe exercise program:

Do you sweat when you exercise?

Do you live in a new home or recently remodeled?

Does your home have new carpet? Paint? Furniture?

Do you have sensitivities to certain smells or environments?

Do you use perfume or cologne?

FEMALE HEALTH HISTORY

Age of first menses			
Date of last period			
Date of last pap smear			
Date of last breast exam			
Date of last mammogram			
Type of Birth control used			
# Pregnancies		# Live Births	
# Living Children		Ages (M/F)	

HEALTH HABITS Check (√) which substances you use and describe how much you use.

	Caffeine
	Tobacco
	Drugs
	Alcohol
	Other

OCCUPATIONAL CONCERNS Check (√) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Please explain:

DIET

	YES	NO
Do you perceive your diet as healthful?		
Do you follow a particular diet?		
Are you a Vegetarian?		
Do you drink soda?		
What kind? How much?		
How much water do you drink?		
Is it filtered water or from the tap?		
Do you take nutritional supplements		
Please List:		

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

practical family health

Dr. Bethany Glynn

Informed Consent to Naturopathic Medical Treatment

I, (print name) _____, request care from Dr. Bethany Glynn, a Washington State licensed Naturopathic Physician. I have sought health care of my own free will and hereby authorize the performance of diagnostic and treatment procedures described to me by Dr. Glynn. I understand that ***if I have been diagnosed by an oncologist as having any form of cancer,*** that by Washington state law, I am required to also be under the care of a medical doctor. I am here for adjunctive and supportive therapies only, including nutritional guidance. Naturopathic medicine utilizes natural therapies as mainstays for restoring one's natural balance and health. These include the use of vitamins, minerals, enzymes, amino acids, fatty acids, natural hormones, concentrated food preparations, botanicals, homeopathic medications, hydrotherapy, therapeutic exercise, dietary modifications, psychological counseling, and other techniques which support the natural processes of the human body. With this knowledge, I voluntarily consent to treatment by Dr. Glynn or their staff, realizing that, as is the case with any medical treatment, no guarantees can or have been given to me by the doctors or staff regarding any cure of my condition. I have been informed of potential risks or side effects involved in any of the diagnostic or treatment procedures. I have read and understand all of the above.

_____ _____

Signature of Patient or Person Authorized to Consent for Patient Date

Laboratory Test Consent Form

Standard or conventional medicine can be slow to incorporate the more progressive and certainly the more natural approaches to health. **This can also include certain types of laboratory testing**. Insurance companies are no more eager to approve and pay for these laboratory tests that the medical profession has yet to acknowledge. For this reason many insurance companies refuse to pay for testing or procedures that are not currently recognized as standard procedure. If insurance will not pay, then you, of course will ultimately make the decision whether or not to have the test run. You will also ultimately be responsible for any costs incurred through said lab testing. We thank you for your understanding and compliance. I, (print name) _____ understand that certain specialized laboratory tests ***are not covered by my insurance plan***. I hereby authorize Dr. Glynn to run the test/analysis that we mutually agree upon and agree that I am fully responsible for any and all charges incurred. **I understand that no laboratory tests will be run without my full consent.**

_____ _____

Signature of Patient or Person Authorized to Consent for Patient Date

IF YOU HAVE NOT ALREADY REVIEWED IT, PLEASE ASK FOR A COPY OF OUR PRIVACY PRACTICES.

I, _____, acknowledge that I have read in full and understand Dr. Bethany Glynn's "Notice of Privacy Practices" I have been offered a copy of said Notice of HIPPA regulations by staff at the Naturopathic Clinic of Issaquah.

_____ _____

Signature of Patient or Person Authorized to Consent for Patient Date