6712 KIMBALL DRIVE SUITE #100 · GIG HARBOR, WASHINGTON 98335 ·
253.853.8853 · FAX 253.853.8855

COLON HYDROTHERAPY - INTAKE FORM

Please PRINT and answer all questions:

Name: ____________________(home ph) ____________(work ph)____________

(cell ph) ____________________E-mail ____________________

Mailing Address:____________________ City ____________________State______ Zip __________

Emergency Contact ____________________ Phone Number ____________________

Occupation: ____________________

Height:__________ Weight: __________ Birthdate: ____________ Age:____________

Why have you chosen to have Colon Irrigation Sessions? Reason ____________________

____

In Pain? __________ Where? ____________________

Have you received colonics before? __________ How many? __________ Where? ____________

Results? ____________________ How often do you eliminate? Times daily:__________

Every Few days__________ Weekly ____________ BM Painful/Difficult ____________

Under Medical Provider's Care? __________ Medical Providers Name ____________________

List prescriptions or over the counter medications used:

____

____

____

CONTRAINDICATION'S: Check and Date if ever had any of the following:

DATE:

______ Abdominal Hernia
______ Abdominal Surgery
______ Abnormal Distension
______ Acute Liver Failure
______ Anemia
______Aneurysm - All Types
______Carcinoma of the Colon
______Cardiac Condition
______ Crohns Disease
______ Colitis
______Dialysis Patients
______ Diverticulosis/Diverticulitis
______ Fissures & Fistulas
______Hemorrhaging
______Hemorrhoidectomy
______Intestinal Perforations
______Lupus
______Pregnant - (due date______)
______Rectal/Colon Surgery
______ Renal Insufficiencies
______Taking medication's which may weaken intestinal walls?

Symptoms: Please Check:

______ Bladder Infection
______Burning/Itching Anus
______Hemorrhoids
______Recent Colonoscopy
______ Bloating
______Constipation
______Rectal Bleeding
______Strain
______Blood in Stool
______ Diarrhea
______Recent Barium Enema
______Use Laxatives
______BM Painful/Difficult
______Infectious Disease
______Vomiting
______Other: ____________________

I have not been diagnosed with any of the above contraindications for colon irrigation.

Client Signature X ____________________ Date ______/_____/_____

Therapist: X ____________________ Physician: ____________________

Dr. Russell L. Kolbo
Dr. McKenzie J. Timmer
Dr. Millie I. Arocho
Dr. Lester E. Griffith
Dr. Jessica L. Corbeille
Dr. Fred W. Bomonti
Kirsty Docken EAMP, LAC

Financial Policy

Thank you for choosing Mt. Rainier Clinic for your healthcare needs. We are committed to providing you with the best possible care. Your clear understanding of our financial policy is an important part to our professional relationship. We require that you read, agree to and sign this policy prior to any treatment.

Payment

Payment of services, supplies, supplements, lab kits and all food items are required at each visit. We accept cash, check or credit card. Payment will include any applicable copays and/or non-covered services.

Insurance

Mt. Rainier Clinic participates in several insurance plans. We will attempt to verify your coverage however; you are advised to check with your insurer's member services department prior to your first visit. We will file the insurance claims on your behalf for covered services only. We do not guarantee that any of your charges will be covered by your insurance. If payment of your services is denied in part or in full by your insurance, you will be charged accordingly.

Referrals

If a referral is required prior to being seen by our providers it is your responsibility to obtain one that is properly dated.

Collections

You will receive a monthly statement from our clinic for any unpaid balances. Payment is due immediately. After 90 days your account becomes seriously past due. If your account balance becomes 120 days past due and out attempts to collect from you are unsuccessful, we will turn your balance over to a collection agency.

Returned Checks

If a check is returned for insufficient funds, all charges incurred by Mt. Rainier Clinic will be billed directly to you.

If you have any questions regarding the Financial Policy or any billing statements you receive from Mt. Rainier Clinic please call our billing team at (253)853-8853, option 4.

____ ________________________

Signature of Responsible Party Date

____

Printed Name

Dr. Russell L. Kolbo
Dr. McKenzie J. Timmer
Dr. Millie I. Arocho
Dr. Lester E. Griffith
Dr. Jessica L. Corbeille
Dr. Fred Bomonti

Acknowledgement and Receipt of Notice of Privacy Practices

Our Notice of Privacy Practice provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this acknowledgement. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting a request.

By signing this form, you acknowledge receipt of our notice regarding use and disclosure of protected health information about your treatment, payment and health care operation as described in the notice.

I authorize Mount Rainier Clinic to leave messages at the contact listed below, (such as confirmation calls and test results.)

☐ Home Phone______________________ ☐ Mobile Phone________________________

☐ Work Phone______________________ ☐ Email____________________________

HIPAA Release of Information:

Please list anyone you want to have verbal and/or physical access to your health care information. This information will remain in place until you direct Mount Rainier Clinic otherwise

Name: **Relationship:** **Phone Number:**

____

____

____

Emergency Contact:

Please list your emergency contact if different from above.

Name: **Relationship:** **Phone Number:**

____

____

Patient Name____

Patient/Representative Signature____

Date______________________________

____

For Office Use Only:

I have attempted to obtain the patient's signature on this form, but was not able to obtain it for the reason listed below:

Reason:_________________________________Staff member initials:____________Date:____________

6712 Kimball Drive Suite 100 | Phone: 253 853.8853
Gig Harbor, WA 98335 | Fax: 253 853.8855
www.MtRainierClinic.com

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MISSED APPOINTMENT POLICY

Our goal is to provide quality individualized care in a timely manner. We understand that there are times when you must miss an appointment due to emergencies or unavoidable obligations for work or family; however, when a patient misses a scheduled appointment they could be preventing another patient from getting much needed treatment. That patient needing treatment could be you!

Cancellation of an Appointment

In order to be respectful of the needs of other patients, please be courteous and promptly call Mount Rainier Clinic if you are unable to show up for an appointment. This time will be reallocated to someone in need of treatment. If necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will allow other patients access to timely medical care.

How to Cancel Your Appointment

To cancel appointments, please call (253) 853-8853. If you do not reach the receptionist, you may leave a detailed message on our voicemail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

Late Cancellations/Late Arrivals:

A cancellation is considered "late" when a patient cancels their appointment with less than 24-hour notice. As a courtesy to other patients, if you arrive to your scheduled appointment more than 15 minutes late, you will be required to reschedule.

No-Show Policy:

A "no-show" is someone who misses an appointment without cancelling in the manner listed in the above sections. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show" and results in a "missed appointment fee" of the value listed below:

Missed Appointment Fees:

Office Visits, HBOT, and IV Therapy Appointments:

$75

Chiropractic and Acupuncture Appointments:

$50

Colonic

$40

By signing this form I understand, if I do not cancel my scheduled appointment, in a manner listed above I will be charged the appropriate amount.

______________________________ ________________

Signature of Responsible Party Date

____

Printed Name

______________________________ ________________

Witness Date