Lynn Chadd
Natural Health

Women's New Patient Packet

1. **Office Locations, Pricing, Payment & Cancellation Policies**

2. **How to Self-Bill Insurance (we do not accept any insurance)**

3. **Client Provider Agreement**

4. **Medical History Intake Form** — To expedite the scheduling process, please complete prior to calling for a New Patient appointment. A credit card number will be required at the time of scheduling to reserve your appointment time (MasterCard and Visa accepted).

Additional Medical Records

If applicable, please include the following medical records. These can be mailed ahead of time, or bring them with you to your scheduled appointment.

1. Most recent mammogram
2. Most recent pap smear
3. Most recent bone density scan
4. All blood work completed within the last year
5. Any other information pertinent to your situation

Congratulations on taking a positive step toward improving your health. I look forward to meeting with you soon!

Sincerely,

Lynn Chadd, ARNP

General Office Information

Office Hours 9:00-3:00 p.m. — Monday through Thursday
All calls received after 3:00 p.m. will be be returned the following business day.
Appointments 509-548-1801 / info@lynnchadd.com

Poulsbo Office 19319 7th Ave, Suite 106, Poulsbo, WA 98370

New Patient Consult Appointment
Includes first follow-up appointment. Please allow 45-60 minutes for this New Patient appointment. Consult appointments can be face-to-face or via Telehealth — the cost is the same.

Saliva Hormone Testing
Saliva testing is required to be treated with bio-identical hormones. On average, saliva testing is completed when treatment is initiated, when prescriptions are adjusted, and yearly when treatment has stabilized. Frequency of saliva testing will vary from person to person, depending on response to treatment. Kits are purchased through our office.

Established Patient Follow Up Appointment
A follow up appointment is needed to review saliva test or lab results. The follow up appointment is NOT included in the cost of any saliva or lab test.

Payment Policy

Please be aware that no insurance is accepted. Payment is due at the time of service by Visa, MasterCard, check, or cash. We will obtain a credit card number from you when you make your appointment and your visit will be charged on the day of service.

Current pricing for all services is available at lynnchadd.com.

Cancellation Policy

A 48-hour notice is required for all patient appointment cancellations. We reserve the right to charge in full for your appointment if you cancel with less than 48-hour notice or fail to show up for your scheduled appointment time. Thank you for your understanding and cooperation!

How to Self-Bill Your Insurance

Please be aware of the following:

- NOT all plans allow self-billing, and Medicare does NOT permit patients to self-bill.
- It is the responsibility of the patient to consult their insurance plan for instructions and appropriate forms for self-billing.
- At the time of your visit you will receive an itemized receipt with necessary insurance codes to facilitate self-billing.
- It is advised to make copies of all forms prior to submitting insurance claims.
- Lynn Chadd is an Out-of-Network Provider/Non-Preferred Provider who is not contracted with any insurance companies.

Call or go online to your insurance company. We recommend that you do this before scheduling your first appointment. This way you are sure about your insurance coverage before getting started. It is best for everyone involved to not get started on our program if you are not able to continue due to lack of insurance reimbursement.

Tell them that you will be seeing an out-of-network or non-participating provider and you need the self-billing form and instructions on how to bill the insurance company for reimbursement. Please advise your insurance to reimburse you directly as we cannot accept their payments on your behalf. (Often a different billing address is provided for claims that have been prepaid). The entire process and forms used vary according to your insurance company and plan.

Once you have received the form, complete and attach the sales receipt you received from our office. The sales receipt includes the visit code (CPT) and the Diagnosis Code (iCD-10). When it asks for these on the form write “See Attached”. It is a good idea to highlight the codes and the tax ID number to prevent oversight and possible denial by the claims department.

If your claim is denied, contact your insurance administrator and ask why. Sometimes claims are denied mistakenly and require further follow up on your part.

Sometimes insurance companies ask for records before they will pay a claim. If you receive a request for records from your insurance company, call our office and we will provide you with the necessary supporting information for your claim.

Client Provider Agreement

- **I understand that Lynn A. Chadd, ARNP does not accept insurance as payment and that I am responsible for payment in full at the time of service.**
- **I have read and agree with the cancellation policy.**
- I understand that if Medicare is my insurance, I cannot self bill Medicare for reimbursement as per Medicare's billing policy. I am agreeing to pay "out of pocket" for all services, at the time of service.
- I understand that the main focus of Lynn Chadd's practice is preventive healthcare, integrative care of chronic disorders, and treating hormone imbalance in men and women. **I understand that Lynn Chadd does not provide after-hour, urgent, emergency or on-call care.**
- I have been advised to have a Primary Care Provider for my general health care needs.
- I have been advised that in the event of an emergency I should dial 911 or go to my local emergency room.
- I have provided accurate medical history information on the Medical History Intake Form.
- I understand that all of my records and information will be confidential according to "The Healthcare Privacy Act".

Legal Name _____ **Date of Birth** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone _____ **Work Phone** _____

Cell Phone _____ **Preferred Phone for Msgs** _____

Email _____

We will use email to deliver our newsletter, messages, and general correspondence. Please opt in or out of email communication by circling your preference below.

Newsletter? Yes No Messages, reminders and general correspondence? Yes No

Signature _____ **Date** _____

Medical History Intake Form — Women

Legal Name _____

Date of Birth _____ **Date Form Completed** _____

Health Maintenance

Date of last mammogram _____ Normal Abnormal

Date of last pap smear _____ Normal Abnormal

Do you have a history of abnormal pap smears? No Yes

Date of last bone density test _____ Normal Abnormal

Date of last colon cancer screening _____ Normal Abnormal

Date of last diabetic blood screening _____ Normal Abnormal

Date of last cholesterol blood screening _____ Normal Abnormal

Lifestyle

Do you smoke or use tobacco products now? No Yes — How many per day? _____

Have you smoked or used tobacco in the past? No Yes — When and how long? _____

Do you drink alcohol? No Yes — How much and how often? _____

How many caffeinated beverages do you drink per day? _____

How many sodas do you drink per day? _____

Do you exercise regularly? No Yes — How much and how often? _____

What type of work do you do? _____

Do you practice stress management techniques? No Yes — What and how often?

_____

Medical History Intake Form – Women

Typical Daily Nutrition / Food Intake

First Meal	Second Meal	Third Meal	Snacks

Medication Allergies No Yes – Please list

Medication	Type of Allergic Reaction
1.	
2.	
3.	

Medications & Supplements

Medication Name	Dose	Times a Day	Prescribed By
1.			
2.			
3.			
4.			
5.			
6.			

Supplement Name	Dose	Times a Day
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Medical History Intake Form – Women

Surgeries

1.
2.
3.
4.
5.

Family History Please circle all that apply and indicate your relationship.

Breast Cancer	Maternal	Paternal
Colon Cancer	Maternal	Paternal
Heart Disease	Maternal	Paternal
Diabetes	Maternal	Paternal
Osteoporosis	Maternal	Paternal
Thyroid Disorders	Maternal	Paternal

Other:

Menstrual / Menopause History

Date of last menstrual period? _____ (Skip next section if you no longer have periods)

How often do you have periods? _____ Tampon/pad size used on heaviest days?

Super Plus Super Regular Pads Both Other

On your heaviest days, how often do you change your protection? _____

Average length (in days) of periods _____ Any spotting in between your periods? No Yes

Do you experience pre-menstrual symptoms? No Yes – Please indicate

Irritability Bloating Fatigue Breast Tenderness Other

Do you have painful periods? No Yes

Medical History Intake Form – Women

Obstetrical History

Number of Pregnancies _____ Number of Full Term Deliveries _____

Vaginal or Cesarean Deliveries _____ Miscarriages or Terminations _____

Contraception

Tubal Ligation Vasectomy Birth Control Pills Condoms Hysterectomy IUD

Other _____

Hormones

Any current hormone replacement therapy? No Yes – List in Medications on Page 6

Any problems with hormone replacement in the past? No Yes – Please describe what was taken and reaction

_____

_____

_____

Medical History Intake Form – Women

Personal Medical History Please circle all that apply and provide explanation to the right.

Breast Cancer

Ovarian Cancer

Uterine Cancer

Colon Cancer

Other Cancers

Heart Disease

Stroke

High Cholesterol

High Blood Pressure

Blood Clotting Problems

Respiratory Conditions

Diabetes

Osteoporosis or Osteopenia

Thyroid Problems

Polycystic Ovarian Syndrome

Depression

Anxiety

Arthritis

Epilepsy or Seizures

Ulcers

Urinary Problems

Headaches/Migraines

Visual Problems

Other:

Medical History Intake Form – Women

Please rate the severity of the symptoms you are currently experiencing.

Symptom	None	Mild	Moderate	Severe
Hot flashes	0	1	2	3
Night sweats	0	1	2	3
Vaginal dryness	0	1	2	3
Pain with intercourse	0	1	2	3
Dry eyes	0	1	2	3
Heavy periods	0	1	2	3
Painful periods	0	1	2	3
Uterine fibroids	0	1	2	3
Endometriosis	0	1	2	3
Water retention	0	1	2	3
Bloating	0	1	2	3
Breast tenderness	0	1	2	3
Depression	0	1	2	3
Difficulty with memory	0	1	2	3
Foggy thinking	0	1	2	3
Mood swings	0	1	2	3
Fatigue	0	1	2	3
Sleep disturbance	0	1	2	3
Anxiety	0	1	2	3
Irritability	0	1	2	3
Headaches	0	1	2	3
Heart palpitations	0	1	2	3
Acne	0	1	2	3
Hair loss	0	1	2	3
Weight gain	0	1	2	3
Decreased sexual desire	0	1	2	3
Decreased sexual arousal	0	1	2	3
Decreased sexual response	0	1	2	3
Thinning skin	0	1	2	3
Muscle aches	0	1	2	3
Joint pain	0	1	2	3
Other:	0	1	2	3

Medical History Intake Form – Women

Are you experiencing any of these symptoms?

Snoring? No Yes

Sleep apnea (stopping breathing while sleeping)? No Yes

Dozing while seated or inactive? No Yes

Nodding off while driving? No Yes

Any additional concerns you would like to discuss with Lynn?