

Lynn Chadd  
**Natural Health**

## Men'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 PSA blood test results
2. Most recent prostate exam notes
3. All blood work completed within the last year
4. 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 returned the following business day.

**Appointments** 509-548-1801 / [info@lynnchadd.com](mailto: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](http://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** \_\_\_\_\_

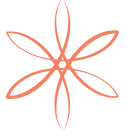
**Email** \_\_\_\_\_

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 – Men

**Legal Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **Date Form Completed** \_\_\_\_\_

## Health Maintenance

Date of last prostate exam \_\_\_\_\_ Normal Abnormal

Date of last PSA blood 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 – Men

## 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

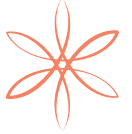
- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Supplement Name

Dose

Times a Day

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.



# Medical History Intake Form – Men

## Surgeries

- 1.
- 2.
- 3.
- 4.
- 5.

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

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

Other:



# Medical History Intake Form – Men

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

Heart Disease

Stroke

High Cholesterol

High Blood Pressure

Enlarged Prostate

Urinary Problems

Prostate Cancer

Other Cancers

Ulcers

Thyroid Problems

Blood Clotting Problems

Respiratory Conditions

Diabetes

Arthritis

Depression

Anxiety

Epilepsy or Seizures

Headaches/Migraines

Visual Problems

Osteoporosis or Osteopenia

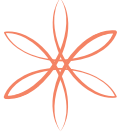
Other:



# Medical History Intake Form – Men

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
Water retention	0	1	2	3
Bloating	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 erectile function	0	1	2	3
Foggy thinking	0	1	2	3
Difficulty with memory	0	1	2	3
Muscle weakness	0	1	2	3
Decreased muscle size	0	1	2	3
Decreased stamina	0	1	2	3
Hair loss	0	1	2	3
Fatigue	0	1	2	3
Sleep disturbance	0	1	2	3
Depression	0	1	2	3
Anxiety	0	1	2	3
Mood swings	0	1	2	3
Irritability	0	1	2	3
Headaches	0	1	2	3
Snoring	0	1	2	3
Dozing while seated or inactive	0	1	2	3
Nodding off while driving	0	1	2	3
Sleep apnea (stopping breathing while sleeping)	0	1	2	3
Other:	0	1	2	3



# Medical History Intake Form – Men

**Any additional concerns you would like to discuss with Lynn?**

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