Print Form

Virender Sodhi, M.D. (Ayurved), N.D.
Shalinder Sodhi, B.A.M.S., R.D.M.S., N.D.
Anju Sodhi, B.A.M.S., N.D.
PANCHA KARMA TECHNICIAN:
Amy Lemay

2115 - 112th Ave NE, suite 200
Bellevue, WA 98004-2946 | USA
425.453.8022 · Fax 425.453.1408
reception@ayurvedicscience.com
www.ayurvedicscience.com

PATIENT INFORMATION AND RELEASE FORM

Patient:_____ _____ _____
Last Name First Name Middle

Address:_____ _____ _____ _____
Street or P.O. Box City State Zip Code

Home Phone:_____ Work :_____ Mobile/Other:_____

Email:_____ Birth Date: _____

Gender: ☐Male ☐Female ☐Other

Occupation: _____

Employer: _____

Employer's Address: _____

Person Responsible for Payment: _____ Relationship: _____

Payer's Home Phone: _____ Payer's Work Phone: _____
Payer's
Address:_____ _____ _____ _____
Street or P.O. Box City State Zip Code

Payer's Employer: _____ Relationship: _____
Employer
Address:_____ _____ _____ _____
Street or P.O. Box City State Zip Code

How did you hear about Ayurvedic & Naturopathic Medical Clinic?

_____

PRESENT HEALTH CONDITION

In your opinion, what are your most important health concerns? Please list these below in order of their significance. Please indicate the problem that motivated you to come today:

1. _____
2. _____
3. _____
4. _____

What other health care are you currently receiving?

_____

_____

_____

YOUR HEALTH HISTORY

Health as a Child: ☐Good ☐Fair ☐Poor

Childhood Illnesses: ☐Scarlet Fever ☐German Measles ☐Measles ☐Mumps
☐Bronchial Problems ☐Rheumatic Fever ☐Diphtheria ☐Other

Hospitalizations (Year & Reason): _____

_____

_____

Surgeries (Year & Type): _____

_____

_____

Immunizations /Vaccinations: ☐Smallpox ☐Polio ☐Typhoid
☐Mumps ☐Tetanus/DPT ☐Influenza

Any Vaccination Reaction: _____

GENERAL SYSTEMS REVIEW

Date of Last Physical Examination: _____ Height: _____ Weight:_____
Weight One (1) Year Ago_____ Max Weight: _____ When? _____
Diagnosis Current or Past: _____

_____

Medications or Supplements – prescription and non-prescription drugs, herbs, & homeopathies you currently take:

_____

_____

_____

Allergies – Food, Drugs, Chemicals, Other (please list all known):

_____

_____

GENERAL SYSTEM REVIEW continued

FAMILY HISTORY	Father	Mother	Brothers	Sisters	Spouse	Child	Other
Age (if living)							
Age (at death)							
Cause of Death							
Cancer							
Diabetes							
Heart Disease							
High Blood Pressure							
Stroke							
Epilepsy							
Mental Disorder							
Asthma, Hay Fever							
Hives, Urticaria							
Anemia							
Kidney Disease							
Glaucoma							
Tuberculosis							
Syphilis							
Other (specify)							

Habits: ☐Alcohol ☐Caffeine ☐Tobacco ☐Cannabis
☐Other Recreational Drugs Other: _____

Diet History:

Any Dietary Restrictions?_____

How is Your Appetite? Do You Eat ☐ Slowly ☐ Rapidly

How many meals per day do you eat? _____ ☐ Snacks? ☐ Are You a Thirsty Person?

Do you prefer foods to be ☐ Hot In Temperature ☐ Cold In Temperature

Do You Crave: ☐ Hot In Temperature ☐ Cold In Temperature

☐ Sweet ☐ Sour ☐ Spicy ☐ Bitter ☐ Starches ☐ Butter or other Fats

Do You Like Any Particular Foods?_____ Dislike Any? _____

_____

DO YOU LIKE TO EAT THE FOLLOWING FOODS:	Daily	Weekly	Monthly	Never
Grains/Cereals				
Vegetables				
Fruits				
Dairy				
Eggs				
Poultry				
Meal				
Seafood				
Sugar / Honey				
Desserts				
Juices				
Other				

GENERAL SYSTEM REVIEW continued

How is Your Sleep? ☐Good ☐Fair ☐Poor Average Hours of Sleep/Night _____

Do You Exercise Regularly? ☐Yes ☐No If Yes, How Frequently & How Long? _____

What Type of Exercise Do You Like? _____

Other Information

Please Check All That Apply

	PAST	CURRENT
ENERGY		
Fatigue	☐	☐
Night Sweats	☐	☐
Poor Appetite	☐	☐
Sudden Drop in Energy	☐	☐
SKIN & HEAD		
Rashes	☐	☐
Itching	☐	☐
Moles	☐	☐
Growths	☐	☐
Pimples	☐	☐
Dandruff	☐	☐
Loss of Hair	☐	☐
Use of Hair Dye	☐	☐
Changes in Nails	☐	☐
HEAD		
Headaches	☐	☐
Head Injury	☐	☐
Dizziness	☐	☐
EYES		
Impaired Vision	☐	☐
Eye Pain	☐	☐
Tearing	☐	☐
Dryness	☐	☐
Double Vision	☐	☐
Night Blindness	☐	☐
Glasses/Contact Lenses	☐	☐
NECK		
Swollen Glands	☐	☐
Pain & Stiffness	☐	☐
BLOOD		
Anemia	☐	☐
Easy Bleeding, Bruising	☐	☐

	PAST	CURRENT
EARS		
Impaired Hearing	☐	☐
Ringing, Hissing, Buzzing	☐	☐
Earaches, Itching	☐	☐
Ear Infections	☐	☐
Dizziness	☐	☐
NOSE & SINUSES		
Nose Bleeds	☐	☐
Stuffiness	☐	☐
Sinus Problems	☐	☐
Post Nasal Drip	☐	☐
Frequent Colds	☐	☐
MOUTH & THROAT		
Frequent Sore Throat	☐	☐
Sore Tongue	☐	☐
Gum Problems	☐	☐
Hoarseness	☐	☐
Dental problems	☐	☐
Difficulty Swallowing	☐	☐
DIGESTION		
Trouble Swallowing	☐	☐
Heartburn	☐	☐
Stomach Pain	☐	☐
Change in Thirst	☐	☐
Change in Appetite	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Irregular Bowel Movements	☐	☐
Loose Stools	☐	☐
Blood in Stools:	☐	☐
Belching or Gas	☐	☐
Liver/Gall Bladder Disease	☐	☐
Hemorrhoids	☐	☐
	PAST	CURRENT

Other Information Continued

Please Check All That Apply

	PAST	CURRENT
URINARY		
Pain with Urination	☐	☐
Increase in Frequency	☐	☐
Frequency at Night	☐	☐
NEUROLOGIC		
Fainting	☐	☐
Seizures	☐	☐
Paralysis	☐	☐
Muscle Weakness	☐	☐
Numbness or Tingling	☐	☐
Loss of Memory	☐	☐
RESPIRATORY		
Cough	☐	☐
Spitting up Blood	☐	☐
Wheezing	☐	☐
Difficult Breathing	☐	☐
Pain with Breathing	☐	☐
Shortness of Breath	☐	☐
Shortness Lying Down	☐	☐
Shortness at Night	☐	☐
Positive TB Test	☐	☐

	PAST	CURRENT
HEART		
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Rheumatic Fever	☐	☐
Chest Pain	☐	☐
Swelling in Ankles	☐	☐
Palpitation, Fluttering	☐	☐
CIRCULATION		
Deep Leg Pain	☐	☐
Cold Hands/Feet	☐	☐
Varicose Veins	☐	☐
MUSKULOSKELETAL		
Joint Pain	☐	☐
Broken Bones	☐	☐
EMOTIONAL		
Depression	☐	☐
Mood Swings	☐	☐
Anxiety	☐	☐
Tension	☐	☐

AYURVEDIC PSYCHOSOMATIC BODY TYPES & IMBALANCE QUESTIONNAIRE – page 1

Please Answer All Questions

		PAST	CURRENT
ABILITY TO WITHSTAND STRESS			
V	Poor	☐	☐
P	Moderate	☐	☐
K	Strong	☐	☐
TEMPER			
V	Easily Irritated or Provoked	☐	☐
P	Emotional Outbursts or Short Circuit	☐	☐
K	Very Tranquil or Peaceful	☐	☐
APPETITE			
V	Variable	☐	☐
P	Large	☐	☐
K	Little	☐	☐
TYPICAL MEAL SIZE			
V	Small	☐	☐
P	Medium	☐	☐
K	Large	☐	☐
NUMBER OF MEALS TYPICALLY CONSUMED PER DAY			
V	____		
P	____		
K	____		
BOWEL MOVEMENTS			
V	Irregular or Hard/Constipated	☐	☐
P	Irregular or Loose	☐	☐
K	Regularly Formed	☐	☐
NUMBER OF BOWEL MOVEMENTS AFTER TAKING PURGING AGENT			
V	**1** Usually One	☐	☐
P	**4** Or More	☐	☐
K	**2-3**	☐	☐

		PAST	CURRENT
SLEEP PATTERNS			
V	**6** Hours or Less	☐	☐
P	**6-8** Hours	☐	☐
K	More than **8** Hours	☐	☐
MENTAL CONCENTRATION			
V	Strong	☐	☐
P	Moderate	☐	☐
K	Weak	☐	☐
SEXUAL DESIRE			
V	Little	☐	☐
P	Moderate	☐	☐
K	Large	☐	☐
PHYSICAL BUILD			
V	Thin/Hard Weight Gain	☐	☐
P	Medium	☐	☐
K	Heavy/Easy Weight Gain	☐	☐
TASTE PREFERENCES			
V	Sweet	☐	☐
V	Sour	☐	☐
P	Salty	☐	☐
P	Bitter	☐	☐
K	Astringent	☐	☐
K	Pungent (Spicy)	☐	☐
RELIGIOUS BELIEF			
V	No Established Belief	☐	☐
P	Belief as per Convenience	☐	☐
K	Established Belief in God	☐	☐
K	Other Established Belief	☐	☐

AYURVEDIC PSYCHOSOMATIC BODY TYPES & IMBALANCE QUESTIONNAIRE – page 2

Please Answer All Applicable Questions

	PAST	CURRENT
FEMALE REPRODUCTION		
Age Menses Began	_____	
# of Days per Menstrual Flow	_____	
Bleeding Between Periods	☐	☐
Irregular Cycles	☐	☐
Pain during Intercourse	☐	☐
Cramps	☐	☐
Abnormal Vaginal Discharge	☐	☐
Excessive Flow	☐	☐
Pre- or Peri-Menstrual PMS	☐	☐
Date of Last PAP	_____	
Date of Last Menstrual Period	_____	
No. of Pregnancies	_____	
No. of Miscarriages	_____	
No. of Abortions	_____	
Birth Control	☐	☐
If Yes What Type	_____	
Difficulty Conceiving	☐	☐
Menopausal Symptoms	☐	☐
Sexual Difficulties	☐	☐
Sexually Transmitted Disease	☐	☐
Sexually Active	☐	☐

	PAST	CURRENT
BREAST		
Regular Self-Exams	☐	☐
Lumps	☐	☐
Pain or Tenderness	☐	☐
Nipple Discharge	☐	☐

	PAST	CURRENT
ENDOCRINE		
Thyroid Problems	☐	☐
Heat or Cold Intolerance	☐	☐
Hypoglycemia	☐	☐
Excessive Thirst	☐	☐
Excessive Hunger	☐	☐
Easy Weight Gain	☐	☐

	PAST	CURRENT
MALE REPRODUCTION		
Hernias	☐	☐
Testicular Masses	☐	☐
Prostate Problems	☐	☐
Discharge or Sores	☐	☐
Problem Starting Urination	☐	☐
Problem Stopping Urination	☐	☐
Birth Control	☐	☐
If Yes What Type	_____	
Sexual Difficulties	☐	☐
Sexually Transmitted Disease	☐	☐
Sexually Active	☐	☐

The Following Question
Regarding Sexual Preference is Optional
And is Important to us in Assessing your
Risk Factors & Making Proper Recommendations

Heterosexual	☐	☐
Bisexual	☐	☐
Homosexual	☐	☐

Ayurvedic & Naturopathic Medical Clinic

2115 112th Ave NE Ste 4 Bellevue WA 98004

Disclosures and Consent Forms – Please read and sign all forms below:

Financial Policies and Disclosures Statement

Please read and sign this form

1. Dr. Virender Sodhi is contracted with and bills Regence, Premera Blue Cross, Coordinated Care, First Choice Health and Bridgespan Insurances only.

2. Dr. Shailinder Sodhi is contracted with and bills for Premera Blue Cross, Regence, United Health, Cigna and Aetna Insurances only.

3. Dr. Anju Sodhi is contracted with and bills for Premera Blue Cross, Regence, United Health, Cigna and Aetna Insurances only.

4. All services are to be paid at the time of service.

5. All practitioners hold active license(s) or certifications as required in the State of Washington.

6. If a collection service becomes necessary for payment of the account, you agree to pay all collection fees in addition to any balances due.

7. A late fee of 1.5% per month may be added to delinquent balances.

8. Medicare does NOT cover services or supplies provided in this office.

9. All other insurance companies do NOT cover supplies provided in this office.

10. Release of information: By signing this, I give this office permission to release information required by law or insurance regulation to insurance agencies involved in my case. This does not give permission for any other release of information by this office, which has not been authorized by me.

I have read, understand, and agree to the above policies:

_____ _____

Signature (Parent / Guardian, if under 18 years old) Date

PLEASE INITIAL THE FOLLOWING:

_____ Notice of Privacy Practices:

The Ayurvedic and Naturopathic Medical Clinic complies with the most recent HIPAA Privacy Practices. If I am not the above named person, my relationship to the patient is:

_____

_____ Consent to Routine Clinical Services: I consent to all services rendered by the doctor, or any other licensed doctor(s) or therapist who are now or will in the future treat me while employed by or associated with the Ayurvedic and Naturopathic Medical Clinic. As in all medical practices I understand that there are risks to manipulation and other routine procedures including but not limited to fracture, injury, stroke, dislocation and sprain. I do not expect the doctor(s) to anticipate and or explain all risk and possible complications. I rely on the doctor(s) to exercise judgment during the course of treatment with regards to any procedure. I understand that no guarantees have been made to me as to the result or cures that may be obtained from examination or treatment. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment. I understand that I am responsible for knowing where my personal items are at all times while in the office and if I choose to remove or place any of my personal items I am doing it voluntarily and the Ayurvedic and Naturopathic Medical Clinic is NOT responsible or liable for any lost, stolen or misplaced items.

_____ Consent to Injections; Ligament and Trigger Point: I consent to all injection procedures rendered by the doctor who are now or will in the future treat me while employed by or associated with the Ayurvedic and Naturopathic Medical Clinic. I understand there are risks to injections including but not limited to severe pain, bruising, inflammation, injury, numbness, allergic reaction and infection. I do not expect the doctor to anticipate and or explain all risk and possible complications. I rely on the doctor to exercise judgment during the course of treatment with regards to any procedure. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

_____ Consent to Intravenous Therapy: I consent to all intravenous therapy procedures rendered by the doctor(s) who are now or will in the future treat me while employed by or associated with the Ayurvedic and Naturopathic Medical Clinic. I understand that there are risks to intravenous therapy including but not limited to pain, bruising, inflammation, injury, infection, allergic reaction and metabolic disturbances. I do not expect the doctor(s) to anticipate and or explain all risks and possible complications. I rely on the doctor(s) to exercise judgment during the course of treatment with regards to my procedure. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment. I understand that IV treatments are NOT covered by insurance and will NOT be billed to insurance companies.

____ Consent to Panchakarma program treatments: I consent to all Panchakarma program procedures rendered by the doctor(s) who are now or will in the future treat me while employed by or associated with the Ayurvedic and Naturopathic Medical Clinic. I understand that there are risks to Panchakarma and do not expect the doctor(s) to anticipate and or explain all risks and possible complications. I rely on doctor(s) to exercise judgement during the course of treatment for my present condition and any future conditions for which I seek treatment. I understand that the Panchakarma treatment programs are NOT covered by insurance and will NOT be billed to insurance companies.

_____ For ANY patient who may be consulting in this office with regard to <u>cancer / integrative oncology care,</u> they should be aware that the laws of the State of Washington restrict the

primary treatment of cancer for patients with cancer diagnoses to physicians who are MD or DO licensed. The physicians at the Ayurvedic and Naturopathic Medical Clinic are licensed naturopathic physicians (ND or NMD).

Any involvement in diagnosis, treatment or other means by healthcare providers who do not have MD or DO qualifications should be considered adjunctive or ancillary care. It is always advisable for patients with cancer to seek the advice and care of a qualified Oncologist, but to fulfill the requirements for Washington must at least have a health care relationship with an MD or DO physician.

BY INITIALING ABOVE I acknowledge that I have been informed of the law in the State of Washington regarding primary cancer treatment, and as a patient will direct my healthcare in whatever way best suits my own personal needs and desires.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

I understand that as part of my healthcare, the Ayurvedic and Naturopathic Medical Clinic creates and maintains health records describing my health history, symptoms, examination with test results, diagnoses, treatment and any plans for future care and treatment. I

I understand and have been provided a copy of Notice of Health Information Privacy Practices summary to review, which provides a description of information uses and disclosures. I understand I have the right to request a complete copy of the Notice of Health Information Privacy Practices.

I understand that the Ayurvedic and Naturopathic Medical Clinic reserves the right to change their notice and practices. Changes will be posted in the reception area.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or normal healthcare operations and that the Ayurvedic and Naturopathic Medical Clinic is not required to agree to restrictions I have requested.

By signing below, I agree that I have reviewed the Notice of Health Information Privacy Practices at the Ayurvedic and Naturopathic Medical Clinic.

Signature: Date:

_____

Printed Name:

_____

If signed by person other than patient, check relationship to patient:

Guardian Durable Power of Attorney Parent:

_____

Adult Child Spouse/Domestic Partner Adult Sibling:

_____

CONSENT FOR LEAVING MESSAGES

CONSENT TO LEAVE MESSAGES/SHARE INFORMATION WITH FAMILY AND FRIENDS

I understand that my healthcare information at the Ayurvedic and Naturopathic Medical Clinic is protected and I have received a copy of their Notice of Health Information Privacy Practices.

CONSENT for LEAVING MESSAGES (please check box) □ YES □ NO

I consent to information regarding myself (or my child's/under the age of 18) test results or detailed appointment reminders/instructions to be left on my voice mail or answering machine, text messages, and email.

If yes, please list allowed phone numbers and/or email:

Cell _____

Home _____

Work _____

Email _____

I consent to information regarding workshops, lectures, events, and radio show to be left on my voice mail or answering machine, text messages, and email.

If yes, please list allowed phone numbers and/or email:

Cell _____

Home _____

Work _____

Email _____

CONSENT FOR SHARED INFORMATION WITH FAMILY AND FRIENDS

I wish family or friends to have access to my health care information. The name(s) listed below are family or friends to whom I grant access to my healthcare information. I will rely on the professional judgment of my provider and his/her designee to share such information, as they deem is minimally necessary. I understand that information is limited to verbal discussions and that no paper copies of my protected health information will be provided without my signature on a Release of Protected Health Information Form.

	NAME	RELATIONSHIP
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
	_____	_____
	Patient Name	Date of Birth
	_____	_____
	Patient/Parent Signature	Date

If signature is not by the patient, please indicate Name and Relationship:

_____

This consent will be considered valid until such time as I cancel it in writing. I reserve the right to cancel it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. I understand that any cancellation can only be applied to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.

Consent Highlights

A basis for planning my care and treatment

A means of communication among the many health professionals who contribute to my case

A source of information for applying my diagnosis to my bill

A means in which a third-party payer can verify that services billed were actually rendered

A tool for routine healthcare operations such as assessing quality and reviewing competence of health care professionals.

Virender Sodhi, MD (Ayurved), ND
Shailinder Sodhi, BAMS, RDMS, ND
Anju Sodhi, BAMS, ND

2115 112th Ave NE
Bellevue, WA 98004
425-453-8022 / FAX: 425-451-2670

TELEMEDICINE INFORMED CONSENT

Informed Consent for Telemedicine Services

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Security
Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits

- Improved access to medical care by enabling a patient to remain at a remote site
- More efficient medical evaluation and management
- Obtaining expertise of a distant specialist
- Maintaining patient safety during a pandemic or declared state/federal emergency

Possible Risks
As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (ie. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions, allergic reactions, or other judgment

In the event that my telemedicine session is disrupted or distorted by technical failures, I would like to be contacted via telephone at: _____

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information according to the patient medical records policies set by the clinic.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time.
5. I understand that my telemedicine appointment may involve electronic communication of my personal medical information to other medical practitioners if a referral is warranted.
6. I understand that it is my duty to inform my physician of electronic interactions regarding my care that I may have had with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine, but that no results can be guaranteed or assured.
8. I understand that telemedicine has its limitations, and that there is no guarantee that this telemedicine consultation will eliminate the need for me to see a health care provider in person. I agree to consult with a local health care provider in person for any necessary physical examinations.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents, including the risks and benefits of telemedicine
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.
- I hereby authorize (clinic name) and its medical staff to use telemedicine in the course of my diagnosis and treatment.

Patient Name: _____

Signature of Patient: _____

Date: _____

Ayurveda - The Naturopathic Medicine of India
Ayurveda
AYURVEDIC & NATUROPATHIC MEDICAL CLINIC
Wealth of Health

Virender Sodhi, M.D. (Ayurved), N.D.
Shalinder Sodhi, B.A.M.S., R.D.M.S., N.D.
Anju Sodhi, B.A.M.S., N.D.
PANCHA KARMA TECHNICIANS:
Amy LeMay

2115 - 112th Ave NE, suite 200
Bellevue, WA 98004-2946 | USA
425.453.8022 · FAX 425.453.1408
reception@ayurvedicscience.com
https://ayurvedicscience.com

Patient Name: _____
Last First Middle or Initial
Home Phone: ( )_____Work Phone: ( )_____
E-Mail Address: _____ Birth Date:_____

Sex: Male _____ Female _____ Other_____ Doctor Name: _____

Insurance Name: _____
Address:_____
Phone Number: _____
Customer Service Representative:_____
Subscriber Name: _____
Last First Middle or Initial
Subscriber Date of Birth:_____
Subscriber Address if Different:_____

ID Number: _____ Naturopathic Coverage? _____

Group Number: _____ Office Co-Pay/Co-Ins: _____

This form is used so that you can verify your insurance eligibility. Prior to your visit, please check to see if you have Naturopathic Office Visit coverage. If not, you must agree to take financial responsibility to pay the physician's usual and customary rate.

I agree to these terms and conditions.

Patient Signature _____

Signature of Guardian if Minor: _____

Please verify insurance information prior to your visit.
Once you have completed all the enclosed information, please email it to us reception@ayurvedicscience.com or fax it to 425-453-1408

Virender Sodhi, M.D. (Ayurved), N.D.
Shalinder Sodhi, B.A.M.S., R.D.M.S., N.D.
Anju Sodhi, B.A.M.S., N.D.
PANCHA KARMA TECHNICIANS:
Amy LeMay

2115 - 112th Ave NE, suite 200
Bellevue, WA 98004-2946 | USA
425.453.8022 · Fax 425.453.1408
reception@ayurvedicscience.com
ayurvedicscience.com

MISSED OR LATE APPOINTMENT POLICY

I am fully aware that: Dr. Virender Sodhi, Dr. Shailinder Sodhi, and Dr. Anju Sodhi allow a specific amount of time for my treatment, and if I am late for my appointment, my treatment duration may be adjusted to conform to the respective doctor's treatment schedule.

In case I am late for Spa Services or Panchakarma treatment appointments and do not notify anyone, I acknowledge that I will bear the financial responsibility for this.

As an existing patient, I agree to provide at least **24 hours' notice** if I need to cancel or reschedule. If I fail to do so, I will be charged a **$140 fee** for missed or late cancellations. For **new patients**, a **48-hour notice** is required, otherwise, I agree to pay the **$265 fee** that applies to missed appointments.

These fees are **not covered by insurance** and will be my responsibility. I also acknowledge that I am financially responsible for all services provided and that **full payment is due at the time of service**. Any outstanding balances may incur finance charges.

I understand past-due amounts will be subject to finance charges.

X _____
Signature of Patient

X _____
Signature of Responsible Party (if not patient)

Printed Name of Patient & Date

_____

Printed Name of Responsible Party & Date

_____