NATURAL Health Works

710 John Adams St
Oregon City, OR 97045
p. 503-722-7776 / f. 503-723-0789
www.naturalhw.com / info@naturalhw.com

PERSONAL AND INSURANCE INFORMATION

Name: _____
Last First Middle Initial

Date of Birth: ___/___/___ Email Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Mobile Phone#: _____ Home Phone#: _____

Employer: _____ Work Phone#: _____

Marital Status: Married __ Divorced ___ Widowed ___ Single ___ Domestic Relationship ___

Primary Care Physician: _____ Phone#: _____

Emergency Contact: _____ Phone#: _____

Related to a Motor Vehicle Accident: Y / N Date of Injury: _____

Related to a Worker's Compensation: Y / N Date of Injury: _____

Primary Insurance: _____

Policy #: _____ Group #: _____

Guarantor: _____ Relation: _____ D.O.B. _____

Guarantor Address: _____

City: _____ State: _____ Zip Code: _____

Secondary Insurance: _____

Guarantor: _____ Relation: _____ D.O.B. _____

Guarantor Address: _____

City: _____ State: _____ Zip Code: _____

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MEDICAL HISTORY

Patient Name: _____ **DOB:** _____

How did you hear about us? _____

What is the purpose for your visit? _____

Please share your primary goal for treatment: _____

Please describe your symptoms: _____

Are your symptoms getting worse or staying the same, coming or going: _____

Is there anything that makes it worse? _____

Is there anything that makes it better? _____

Have you had any diagnostic studies in the past 12 months? Please circle.

EKG	EEG	
CT Scan	DEXA Bone Scan	
X-ray	Mammogram	Other: _____
MRI	Colonoscopy	Other: _____

Medication list: _____ _____

_____ _____

_____ _____

_____ _____

Health habits:
Indicate substances you use and describe use –
Caffeine _____
Tobacco _____
Drugs _____
Alcohol _____
Other _____

Occupational concerns:
Indicate if you are exposed to –
Stress _____
Hazardous substances _____
Heavy lifting _____
Other _____

REVIEW OF SYSTEMS

General:
_____ Chills
_____ Depression
_____Dizziness
_____Fainting
_____ Fever
_____ Forgetfulness
_____ Headache
_____ Sleep loss
_____Weight loss
_____ Weight gain
_____ Excessive tiredness
_____ Nervousness
_____ Sweats

Muscle/Joint/Bone:
Pain, weakness or numbness in:
_____ Arms _____ Hips
_____ Hands _____ Shoulders
_____ Back _____ Feet
_____ Legs _____ Neck

Gastrointestinal:
_____ Poor appetite
_____ Bloating
_____ Bowel changes
_____ Constipation
_____ Diarrhea
_____ Gas
_____ Hemorrhoids
_____ Indigestion
_____ Stomach pain
_____ Vomiting
_____ Heartburn

Eye/Ear/Nose/Throat:
_____ Bleeding gums
_____ Blurred vision
_____ Crossed eyes
_____ Double vision
_____ Vision flashes
_____ Vision halos
_____ Sinus problems
_____ Loss of hearing
_____ Earache
_____ Ear discharge
_____ Ringing in ears
_____ Difficulty swallowing
_____ Hay fever
_____ Hoarseness
_____ Nosebleeds

Women Only:
_____ Abnormal Pap Smear
_____ Bleeding between periods
_____ Breast lump
_____ Extreme menstrual pain
_____ Hot flashes
_____ Nipple Discharge
_____ Painful intercourse
_____ Vaginal discharge
Last pap: _____
Last menstruation: _____
Length of last period: _____
days between cycles: _____
Regular cycle – Y / N
Age of first period: _____
Pregnancies: _____
Deliveries: _____

Men Only:
_____ Breast lump
_____ Erection difficulties
_____ Penis discharge
_____ Sore on penis
_____ Lump in testicles

Skin:
_____ Bruise easily
_____ Hives
_____ Itching
_____ Changes in mole(s)
_____ Rash
_____ Scars
_____ Sore that won't heal

Genito-urinary:
_____ Blood in urine
_____ Lack of bladder control
_____ Frequent urination
_____ Painful urination

_____ Diabetes
_____ Kidney: _____

Hospitalizations/Surgeries:

Year	Hospital	Reason for Hospitalization and Outcome

Family History

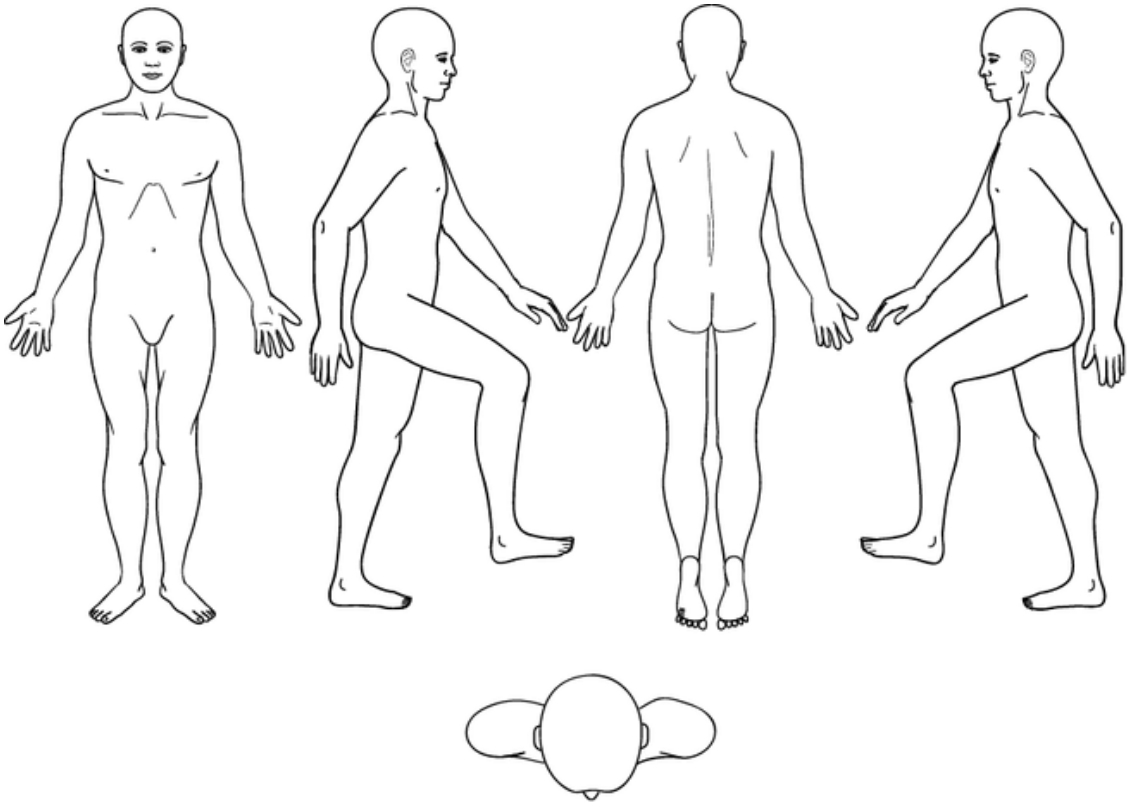
	Age	State of Health	Age of Death	Cause of Death
Father				
Mother				

Have you ever had a blood transfusion? Y / N
If yes, approximate dates _____

Please mark the diagrams below to indicate where on your body you feel:

xxx Pain	*** Stabbing	/// Numbness/Tingling
ooo Aching	+++ Burning	^^^ Surgeries

Please rate your pain on a scale from 1-10 (10 being the worst possible): _____



***Please also indicate any scar sites**

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Authorization for Patient Communication

I authorize Natural Health Works, PC staff to leave private detailed or confidential health information messages on my voicemail:

Home: _____

Cell: _____

I authorize protected health information to be sent to my email*

Email address: _____

*Please note: email communications are not encrypted and while efforts are made to ensure privacy, confidentiality cannot be guaranteed and patients are responsible for securing their part of the communication. The originating email address should not be used to send medical information or questions.

Printed name: _____

Patient signature: _____

Date: _____

Please sign below if you would like to receive appointment reminders, monthly newsletters including updates about new services, treatment options and/or events at Natural Health Works, PC.

Patient Signature: _____

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Financial Policy

PATIENT RESPONSIBILITY

Patients are responsible for all charges resulting from treatment provided by Natural Health Works, PC. Please understand that your insurance policy is an agreement between you and your insurance company. It is your responsibility to pay for any outstanding balance not paid or covered by your insurance company. Payment for provided treatment is collected at the completion of your appointment.

CO-PAYMENT/DEDUCTIBLES/CO-INSURANCE

Co-payment is the amount your insurance policy requires us to collect with each visit and is due at the time of service. The deductible is the total amount your policy requires you to pay before they will pay claims on your behalf. We may ask you to pay the estimated, unmet portion of your deductible before services are rendered. The co-insurance is the percentage of the bill that is your financial responsibility, according to your insurance company.

We accept cash, check, Visa, MasterCard and Discover Card. There is a $25 return check fee.

CANCELLATION & RESCHEDULING FEES

We understand that life happens! If you need to cancel or reschedule your office or acupuncture visit, you must notify us as soon as possible, within **1 business day**. If sufficient notice is not made, there is a **$25** cancellation/rescheduling fee.

If you need to cancel/reschedule your procedure you must notify us within **2 business days**. There will be a **$50** cancellation/rescheduling fee for insufficient notice for procedures (PRP, Prolotherapy, Ozone, IV Therapy)

NO SHOW FEES

You may be charged up to **$50** for not showing for your scheduled procedure and **$25** for not showing to your office visit. If you have a reoccurring pattern of no shows and/or late cancellations, you may be terminated as a patient with Natural Health Works, PC.

PAST DUE AND COLLECTION ACCOUNTS

We reserve the right to send accounts with balances that have been outstanding for over 90 days from the date of service or the date of payment received from your insurance company, whichever is more, to a collection agency. If you have a balance on your account more than 90 days old, you will be referred to Discovery Financial Services, to make payment arrangements. If any portion of your past due amount has been assigned to a collection agency, we will request that you pay one-half of that collection balance before your appointment is scheduled with our office.

The patient's signature (or signature of the patient's parent/legal guardian) acknowledges that you agree and understand the above information.

I have read the above Financial Policy and accept the terms of this agreement.

☐ I have received, or been offered the HIPPA Notice of Privacy Practices

Print Name: _____

Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES
(MEDICAL)

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the provacy of your healh information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** – means providing, coordinating, or managing health care and related serviced by one or more health care providers. An example of this would include a physical examination.

- **Payments** – means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** – include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of September 20, 2010 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Humans Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:
The US Department of Health and Human Services
Office of Civil Rights
200 SW Independence Avenue
Washington, DC 20201
(202) 619-0257 / Toll Free: 1-877-696-6775