Singing River
NATURAL MEDICINE

4970 SW Main Ave, Suite 200
Beaverton, OR 97005
Phone: 503-641-6400 Fax: 503-641-6400

Appointment Date and Time: _____

Name: _____ Date of Birth: _____ Age: _____Gender: M__ F__Other __

Address: _____

City:_____State:_____Zip: _____

Phone # (Main/Home):_____Alternate: _____

E-mail address: _____

Would you like a reminder for future appointments?_____If yes, email reminders or a phone call? _____

Name and address for person responsible for account (if different from above): _____

Address_____

Name, relationship to patient, and phone number of emergency contact person:

_____

Who referred you to this clinic? _____

Office Policy
Singing River Natural Medicine will help you with insurance billing. Please understand if there is a problem with reimbursement, we expect you to pay your account in a timely manner. We will bill your insurance as a courtesy. If any part of your claim is denied or delayed, you are responsible for the bill in full. If your insurance policy does not cover our services, payment will be due at the time of service.

To help you determine if your insurance will cover office visits at this clinic, the following questions need to be answered by your insurance company. Please call them prior to your first visit.

Insurance Information: (Please find out prior to your first visit)
Does your insurance cover Naturopathic Medicine and/or Acupuncture? _____

Can you do a self-referral?_____Are there limitations or exclusions? _____

What are your max. benefits per year?_____What is your yearly deductible?_____What is your co-pay? _____

Policy is in which family member's name?_____ Date of Birth_____

Insurance Company Name:_____Member Identification Number: _____

Group #: _____

Singing River Natural Medicine
Clinic Information and Policies

Naturopathic Medicine works to discover and address the underlying causes of your symptoms or illness, not just to relieve your discomfort. It generally requires a commitment of time, energy and attention on the part of the patient towards regaining good health. Please be prepared to give a detailed history so that Dr. Means can accurately assess your body systems and develop an effective treatment plan. Dr. Means encourages her patients to take an active role in their healing, to ask questions when they have them and to contact her when they are in need.

Directions: Singing River Natural Medicine is located in Old Town Beaverton. From Highway 217, go west on Hwy 10 (Farmington Rd) then south (left) on Watson Rd. Turn west (right) on SW 5th St. We are on the corner of 5th and Main. The clinic is in a new two-story brick and wood building. There is a parking lot behind the building and street parking as well. You can enter either from the parking lot. We are on the second floor.

Scents: Please be aware that many of our patients are extremely sensitive to chemicals. Please refrain from using aftershave, cologne, perfume or any other scented products. We also ask that you do not wear clothes that have been washed with fabric softeners or dried with Bounce.

Cancellations: It is necessary to give us a 24-hour notice if you need to cancel or reschedule an appointment.

If you miss an appointment without timely notification, you will be charged a $99 cancellation fee.

We require that you allow us to keep a credit card on file.

Credit card type_____ Number_____ Expiration_____ CCV_____

Pharmacy: Singing River keeps a well-stocked pharmacy of natural medicines. We are open to serve you Monday, Tuesday, Thursday and Friday from 8:30 a.m. to 5 p.m. and Wednesdays from 8:30 a.m. to 1 p.m.

Authorization: By signing below, you authorize Singing River Natural Medicine to furnish information from your medical records to the parties that are responsible for payment of all or part of the charges for your treatment. This may include your insurance company and their representatives and/or your employer or union if they are involved in processing the claim. You also acknowledge that you have read and understand the policies of Singing River Natural Medicine.

Signature:_____Date: _____

Print Name:_____Date of Birth: _____

Singing River
NATURAL MEDICINE

HIPAA Rights

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Singing River Natural Medicine of our *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Singing River Natural Medicine to obtain a current copy of this notice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that Singing River Natural Medicine is not required to agree to my requested restrictions, but if Medicine does agree, then they are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Medicine has taken action relying on this consent.

Check all that apply to this consent:

___Please do not phone me at home. Use this alternate phone number: _____

___Please do not phone me at work. Use this alternate phone number: _____

___Please do not leave messages on my answering machine.

___Please do not mail appointment reminder cards to me.

___Please do not contact me by e-mail.

___Please send me mail, including my bills, to this alternate address:

_____

___Other request: (please describe):

Patient Name:_____Date of Birth: _____

Signature:_____Date: _____

Singing River
NATURAL MEDICINE

Payments and Billing

Payments are due at the time of service. We accept cash, checks, Master Card, Visa, Discover and American Express.

If your insurance covers Naturopathic Medicine and/or Acupuncture, please provide your insurance card and a picture ID. Please call your insurance provider and give them our tax ID, 27-1582067, to make sure our services are covered.

If your insurance does not cover Naturopathic Medicine or Acupuncture, such as with Medicare, we will give a 20% discount for payment at the time of service. This does not apply to IV therapies and supplements.

Co-payments, deductibles and out of pocket charges are due at the time of service. Also, if for any reason your insurance carrier denies payment, you are responsible for any outstanding balances.

If your insurance company denies payment, we will bill you for the balance due. At times, due to the lapse in time between billing the insurance company and their response, several treatments may have been given and the balance due may be several hundred dollars. If this happens, we are happy to work out a payment plan with you. However, unpaid balances are charged interest at the rate of 1.5% per month ($18% per year).

Please be advised that if we bill you and do not receive a response within three billing cycles, we will reluctantly turn your account over to collections.

High Deductible Health Care Plans
For those of you who have high deductible health care insurance policies, payment in full must be made at the time of service. We will bill your policy so that you may receive some benefit if your annual deductible is met.

Out of Network Insurance Policies
If you are covered by out of network insurance companies, payment in full is required when you receive your treatment. We will provide forms that enable you to bill your healthcare policy holder.

I.V. Therapies
Due to the uncertainty of private insurance companies' coverage of I.V. therapies, payment is due at the time of service, along with any additional co-payments.

This does not apply to our Health Share/Care Oregon Patients.

Please sign below to acknowledge that you have read and understand these policies.

Patient Name:_____Date of Birth: _____

Signature:_____Date: _____

Singing River
NATURAL MEDICINE

Name:_____ **Date of Birth:**_____ **Age:** _____

Please list, in order of importance, your current health concerns:

1) _____

2) _____

3)_____

Other:_____

What was the date of your last physical exam? _____

Major Illnesses and Hospitalizations

Approximate Dates	Illnesses or Reason	Outcome
Pregnancy History		

Family History: Fill in health information about your family. Please include the following diseases/illnesses:

Anemia	Arthritis, gout	Asthma, hay fever	Allergies	Cancer (type)
Chemical Dependency (drug, alcohol)		Diabetes	Environment Toxic Syndrome	
Epilepsy	Heart Disease	Kidney Disease	Mental/Emotional Illness	
Migraines	Stroke	Thyroid Disease	Tuberculosis	

Relationship	Age	Please indicate if your blood relatives have had any of the above diseases	Age at Death	Cause of Death
Mother				
Father				
Brother(s)				
Sister(s)				
Children				
Grandmother (Paternal)				
Grandfather (Paternal)				
Grandmother (Maternal)				
Grandfather (Maternal)				
Other Relatives				

Health Habits: Check all that apply

Health Habit	What Form	Amount	How Often	How Long
Alcohol				
Caffeine				
Tobacco				
Rec. Drugs				
Exercise				

Singing River
NATURAL MEDICINE

Name:_____**Date of Birth:**_____**Age:** _____

Review of Systems: (Check all that apply)

Skin:_____

__acne __dry __moles __rash __ridged nails
__bruising __hair loss __burning feet __herpes __skin tags
__hives __dandruff __spoon shaped nails __warts __eczema
__athletes foot __itching __white bumps __psoriasis __lumps
__poor wound healing

Eyes: _____

__Cataracts __floaters __light sensitive __glaucoma
__discharge __burning __blurred vision __infection
__other_____

Ears: _____

__excessive wax __infection __sound sensitive __vertigo
__hearing loss __itching __ringing __hearing voices
__ear aches __other _____

Nose & Sinuses: _____

__frequent colds __itching __nose bleeds __sinus trouble
__hay fever __polyps __stuffiness __other _____

Mouth & Throat: _____

__silver fillings __grind teeth __bad breath __canker sores
__dentures __hoarseness __bleeding gums __implants
__bridges __gingivitis __gold fillings __infections
__metal braces __root canals __sore tongue __crowns
__trouble swallowing __mouth ulcers __freq sore throats __other _____

Respiratory: _____

__apnea __asthma __bronchitis __cough
__congestion __pleurisy __emphysema __difficulty breathing
__sputum __pneumonia __coughing up blood __pain with breathing
__TB __other_____

__shortness of breath: __at night __lying down __w/exercise

__history of smoking Smoking more than a pack per day___Yes____No

Cardiac:_____

__cold extremities __dyspnea __flushing of skin __palpitations
__edema __chest pain __heart murmurs __high/low B/P
__heart surgery __tight chest __arteriosclerosis __other_____

Singing River
NATURAL MEDICINE

Name:_____**Date of Birth:**_____**Age:** _____

Gastrointestinal: _____

__abdominal pain	__bloating	__diarrhea	__ulcers
__nausea	__anal itching	__colitis	__heartburn
__belching	__irritable bowel	__regurgitation	__difficulty swallowing
__flatulence	__blood	__hemorrhoids	__mucous
__vomiting	__fat intolerance	__change in appetite	
__constipation	__indigestion	__gallbladder problems	__other_____

Bowel Movements/how often:_____**Is this a change?**____**Y**___**N**

Urinary: _____

__burning	__incontinence	__urgency	__kidney disease
__cystitis	__infectious	__stones,kidney	__stones, gall
__frequency	__hesitancy	__at night (how often)	__other_____

Genital (Male): _____

__discharge	__impotence	__itching	__sores
__infection	__testicular pain or mass	__genital herpes	__prostatic hypertrophy
__hernias	__infertility	__painful urination	
__homosexual	__heterosexual	__bisexual	
__other			

Genital (Female): _____

__birth control pill	__endometriosis	__genital herpes	__spotting
__excess hair growth	__# of pregnancies	__hot flashes	__painful menses
__PMS	__irregular cycles	__infertility	__tender breasts
__dysmenorrheal	__hysterectomy	__itching	__yeast infections
__discharge	__excess flow	__pain during intercourse	
__ heterosexual	__homosexual	__bisexual	
age menses began____	average # of days____	age at menopause_____	__menopausal symptoms
__other_____			

Musculoskeletal: _____

__arthritis	__Bone fractures	__joint swelling	__backache
__muscle weakness	__atrophy	__limited range/motion	
__fibromyalgia	__rigidity	__stiffness	__muscle pain
__spasticity	__spasms	__uneven muscular development	
__other			

Singing River
NATURAL MEDICINE

Name:_____ **Date of Birth:**_____ **Age:** _____

Neurologic: _____

__abnormal gait	__confusion	__headaches	__weakness
__delusional	__hyperactivity	__mood swings	__poor memory
__poor coordination	__tension	__learning problems	__irritable
__anxiety	__insomnia	__excessive sleepiness	__tremors
__nightmares	__fainting	__unprovoked anger	__dyslexia
__tics	__autistic	__apathy	__tingling
__numbness	__sciatica	__other_____	

Endocrine: _____

__edema	__excessive thirst	__hyperthyroid	__diabetes
__underweight	__cold intolerance	__excessive hunger	__fatigue
__hypoglycemia	__heat intolerance	__excessive sweating	__overweight
__HRT (hormone replacement therapy)		__other_____	

Immune: _____

__auto immune	__cancer history	__hepatitis	__lupus
__breast implants	__chronic fatigue	__infections	__lyme
__swollen glands	__chemical intolerance	__recurrent illness	__dental implants
__allergic to everything		__other_____	

ENVIRONMENTAL AND TOXIC EXPOSURES_____

Check any that apply to you:

___Live in an agricultural area now or in the past
___Live near industrial areas
___Live in an area that is sprayed with herbicides or pesticides
___Use of pesticides on your personal grounds
___List any known chemical exposure: _____
_____

Are you currently being exposed to any of the following?

__tobacco smoke	__paints	__solvents	__fabric softener
__chemical pet collars	__dry cleaning	__nail polish	__hair dyes/perfumes
__new carpet	__mothballs	__candles	__electric blankets
__metal tooth fillings	__other_____		

What type of heat do you have for your home?

___gas ___oil ___electric __wood pellets ___coal ___other _____

Do you have symptoms of fatigue if you are exposed to any of the above?___Y ___N

Singing River
NATURAL MEDICINE

Name:_____ **Date of Birth:**_____ **Age:** _____

MEDICATIONS/SUPPLEMENTS

Please list any and all prescription medications, over-the-counter medications, vitamins, herbs and stimulants. On your first visit, please bring in all supplemental containers.

Name of Product	**Brand**	**Dose/Frequency**	**How Long?**
Ex) Vitamin C	***Thorne Research***	***1,000 mg per day***	***2 years***
(Add additional pages if necessary)			

Do you have any adverse (opposite) reactions to medications?___N

If yes, please explain: _____

_____

I, the undersigned, agree to the discretion of the physician and give my consent for treatment.

I further agree to pay for services rendered at the time of treatment.

Signature_____ Date: _____