

Evergreen Natural Health Center
6610 SW Capitol Hwy. • Portland, OR 97239 • 503.977.0500
www.drsmantha.com

Welcome to Our Clinic

Our goal is to provide the highest quality naturopathic and Chinese medical care available. We take the time to develop an individualized treatment plan for each patient, treating the whole person and integrating all aspects of his or her health.

Front desk hours are: Monday 10:00 am – 6:00 pm
 Tuesday/Friday 9:30 am – 1:30 pm
 Wednesday 10:00 am – 5:00 pm
 Thursday 11:00 am – 7:00 pm

If you need to pick up pharmacy items, please call ahead and we will have them ready when you arrive.

Our practitioners: We have a team approach, and work together ensuring that our patients have the most comprehensive and reliable care possible.

Dr Samantha Brody- naturopathic physician and licensed acupuncturist
Dr Beverly Butler- naturopathic physician
Janie Stone- licensed acupuncturist

Office hours vary for individual practitioners, are by appointment only and may change on short notice. We require a 24 hour notice for cancellation of appointments. Please see our financial policy for details.

Fees and Services:

- Office visit fees vary with length of appointment and type of care. Please request a handout from our office staff for details.

- Initial appointments are usually an hour, and follow up visits are usually half an hour. Follow up acupuncture appointments are between 45 minutes and an hour. Please note that these times may vary depending upon the condition and your treatment.

- We do bill insurance. Please see our insurance and financial policy for details.

- Supplements recommended by the doctor are rarely covered by insurance. High quality supplements are stocked on site and are available for your convenience. A recommendation from the doctor is by no means a requirement to purchase supplements on site.

- Payment is expected at the time of service. Cash, check and credit cards are accepted.

To reach your practitioner: *If you have a life threatening emergency, please call 9-1-1.*

If you need to reach your practitioner and leave a message on our machine or with one of our staff, she will do her best to return your call by the end of the next business day. If your practitioner feels your question is best answered at a follow up visit, she will have someone call you to schedule an appointment.

Phone consultations longer than 5 minutes will be considered an office visit and will be charged accordingly. Any prescribing by phone is considered an office visit.

Your practitioner may also be available by email for brief inquiries about current treatment or a question about whether or not an appointment should be made. **Please note our email is not currently handled by a secure server so any information you wish to keep private should *not* be sent in this manner.**

Thank you. We look forward to working with you. Please see our website www.drsmantha.com for additional information about our clinic.

PATIENT INFORMATION SHEET

PATIENT:

Last Name: _____ First Name: _____ Middle initial: _____

Gender: M F Date of Birth: ____ / ____ / ____ Age: _____ SS#: _____

Home Address: _____ Apt # _____

City _____ State _____ Zip _____

Phone: (h) _____ (w) _____ (c) _____

Email _____ What is the best way to contact you? _____

May we send you our e-newsletters? Y N (We never share info. You may request removal at any time.)

Employer Name: _____ Occupation: _____

Work Address: _____

Relationship status: Married ___ Separated ___ Divorced ___ Widowed ___ Partner ___ Single ___

Live with: Spouse ___ Partner ___ Parents ___ Children ___ Friends ___ Alone ___ Other ___

How did you hear about our clinic? _____

SPOUSE/PARTNER OR GUARDIAN: *Please circle one.*

Last Name: _____ First Name: _____ Middle initial: _____

Phone: (h) _____ (w) _____ (c) _____

Do you live at the same address? Y N

EMERGENCY: *Name and address of nearest relative or friend not living with you:*

Last Name: _____ First Name: _____ Middle initial: _____

Phone: (h) _____ (w) _____ (c) _____

Relationship to Patient: _____

INSURANCE: *Please present your insurance card(s) to the receptionist.*

Insured's Name: _____ Insured's date of birth: ____ / ____ / ____

RESPONSIBLE PARTY: *Fill out if you are not the patient but are responsible for the bill.*

Responsible Party: _____ Relationship to the patient: _____

Home Address: _____ Apt # _____

City _____ State _____ Zip _____

Phone: (h) _____ (w) _____ (c) _____

Email _____ What is the best way to contact you? _____

SIGNATURE: (Patient, Parent, Legal Guardian or Responsible Party)

I request services X _____

Dr Samantha Brody
Pediatric Intake: 0-5 years

Patient Information:

Name _____ Date _____
 Prefers to be called: _____
 Age _____ Date of birth _____ Gender F M

Parent(s)/legal guardian(s) Information:

Name (s) and relationship _____

Second parent /guardian living at different address:

Name (s) and relationship _____

Sibling names and ages:

How did you hear about our clinic? _____

Pediatrician Information:

Name _____ Phone _____
 Clinic Name _____

Medical History:

What are your concerns regarding your child's health?

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

Medication History:

aspirin	Y N P	antibiotics	Y N P	decongestant	Y N P
Tylenol	Y N P	anti-histamine	Y N P	inhalers	Y N P
ibuprofen	Y N P	asthma meds	Y N P	topical steroids	Y N P

Any other medications? _____

Known allergies to medications: _____

X-rays and Special Studies:

EEG	Y N	psychological evaluation	Y N	
ECG/EKG	Y N	reading/writing	Y N	
hearing	Y N	speech/language	Y N	
MRI	Y N	CT scan	Y N	
x-ray	Y N	other	Y N	

If any of the above are circled Y, please note reason for study:

Dr Samantha Brody
Pediatric Intake: 0-5 years

Injuries/Surgeries/Hospitalizations:

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

Immunizations:

diphtheria	Y N	measles	Y N	small pox	Y N
influenza	Y N	mumps	Y N	polio	Y N
DPT	Y N	MMR	Y N	tetanus	Y N
other:					
Any adverse reactions to immunizations? Y N (Please specify) _____					

Childhood Diseases:

___scarlet fever	___rubella	___measles	___pneumonia	
___chicken pox	___croup	___mumps	___bronchitis	
___other (s)				

Please circle: Y = a condition your child has now, N = never had, P=has had in the past:

hives	Y N P	burning of urine	Y N P	bloody urine	Y N P
eczema	Y N P	frequent urination	Y N P	cries easily	Y N P
bleeding gums	Y N P	heart murmur	Y N P	nervous	Y N P
nose bleeds	Y N P	vomiting spells	Y N P	sleep problems	Y N P
baby acne	Y N P	anemia	Y N P	night sweats	Y N P
high fevers	Y N P	stomach aches	Y N P	sensitive to light	Y N P
chronic rash	Y N P	jaundice	Y N P	body/breath odor	Y N P
hearing loss	Y N P	easy bruising	Y N P	motion/car sick	Y N P
diarrhea	Y N P	flat feet	Y N P	no appetite	Y N P
sore throats/tonsillitis	Y N P	constipation	Y N P	nightmares	Y N P
frequent headaches	Y N P	gas	Y N P	mouth sores	Y N P
frequent colds	Y N P	bleeding tendency	Y N P	unusual fears	Y N P
wheezing	Y N P	joint pains	Y N P	excessive fatigue	Y N P
cough	Y N P	dizzy spells	Y N P	hair loss	Y N P
ear infections	Y N P	asthma	Y N P		

Any other condition not mentioned? _____

Dr Samantha Brody
Pediatric Intake: 0-5 years

Family Medical History :

Was your child adopted?	Y	N	If yes, please inform physician directly.
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General Family Medical History (if known):

(please specify M=mother, F=father, S=sister, B=brother, A= aunt, U= uncle, PGM= paternal grandmother, PGF= paternal grandfather, MGM= maternal grandmother, MGF= maternal grandfather):

arthritis	allergies	hay fever
allergies	eczema	mental illness
cancer	diabetes	heart disease
high blood pressure	other	

Mother's Prenatal History (if known):

Prior pregnancies, miscarriages: _____

Mother's age at child's birth _____

Mother's health during pregnancy:

_____ bleeding	_____ hypertension	_____ cigarettes, alcohol, drugs	
_____ nausea	_____ diabetes	_____ physical or emotional trauma	
_____ illness	_____ thyroid problems	_____ stress	

A Few Final Questions :

1. How does this condition affect your child's day to day life? _____

2. How would your child's life be different if he/she didn't have this condition(s)? _____

3. On a scale of 1-10, how committed are you to working with your child to improve his or her state of health ? _____

4. On a scale of 1-10, how much change are you willing to make at this time for improving your child's state of health? _____

The doctor of the future will give no medicine but will interest his patients in the care of the human frame and in the cause and prevention of disease. -Thomas A. Edison

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PATIENT NOTICE OF PRIVACY POLICY

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED OR DISCLOSED,
AND HOW YOU CAN ACCESS YOUR MEDICAL INFORMATION.**

Patient Rights, Uses and Disclosures of Health Information:

During the course of your care with Evergreen Natural Health Center we may use or disclose personal and health-related information.

- Personal health information and clinical records may be disclosed to another health care provider or hospital.
- Health care and billing records may be disclosed to another party, such as an insurance carrier, or your employer, if they are responsible for payment of your services.
- Name, address, phone number, and health care records may be used to contact you regarding appointment reminders, or your care. (If you are not at home to receive an appointment reminder, we may leave a message. You have the right to refuse authorization to contact you. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care.)

Under federal law, we also may disclose your health information without consent under these circumstances:

- In providing health care services based on the orders of another health care provider.
- In an emergency.
- If we are required by law to provide care, and are unable to obtain your consent.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information other than as outlined above will only be made upon your written authorization. You have the right to inspect and/or copy your health information. You have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided in writing.

Physician Legal Duties:

We are required by state and federal law to maintain the privacy of your patient file and the protected health information. We are also required to provide you with this notice of our privacy practices. We are further required by law to abide by the terms of this notice while it is en effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible.

Complaints and Questions:

If you have a complaint regarding our privacy notice or privacy practices, or if you would like more detailed information, please contact us at 503.977.0500. This notice and any alterations or amendments will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Patient Name (please print) Signature Date

If patient is a minor, or if patient is being represented by another party, your representative signs below:

Personal Representative (please print) Personal Representative Signature Date

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Insurance & Financial Policies
PLEASE READ AND INITIAL

If you have questions about any of our financial policies please contact the office. We appreciate that you have chosen us for your health care and are glad to be of service to you.

Insurance:

In many cases we will be able to call to verify your coverage during your first visit. **If benefits cannot be determined at the time of service and/or if there is any doubt regarding your coverage, payment in full is expected.** If your insurance company remits payment you will be reimbursed when we receive payment. It is important to understand that a verbal confirmation of coverage over the phone from the insurance company does *not* guarantee payment. As is not uncommon for an insurance company to misquote a policy, we recommend reviewing your policy to confirm that the information we received is correct.

In some cases, care agreed to be medically indicated by the physician and the patient may not be covered by insurance (for example: lab tests, well child and annual exams, pre-existing conditions, etc.) Please check with your insurance company to find out if there are any exclusions in your policy. *Initial here* _____

Please note that it is the patient's responsibility to pay for visits and procedures not paid by insurance within a usual and customary time frame (60-90 days). If we are having trouble getting payment from your insurance company within this time frame and you would like us to continue to pursue billing your insurance company, we will require verbal confirmation from you and you will be charged \$15 per claim for the additional time spent in order to help defray the costs of completing the payment for you. *Initial here* _____

Supplements:

Most insurance companies do not cover supplements. Payment in full is expected at time of purchase. We are happy to take a return if the safety seal has not been broken, and it is within 60 days of date of purchase. Please note that there is no requirement to purchase recommended supplements from our office; there are several local stores or web stores that may carry similar products. *Initial here* _____

Late Cancellation/Missed Appointments:

There will be a \$50.00 charge for all no-show and/or appointment cancellations with less than 24 hours notice. After two missed appointments, you will be charged for the entire time reserved for you on the schedule. If you are scheduled for naturopathic and acupuncture on one day, this is considered two appointments as two slots have been reserved on the schedule. Please note that we place appointment reminder calls as a courtesy. If you do not receive a reminder call prior to your appointment, the missed appointment fee still applies. *Initial here* _____

Methods of Payment:

We accept cash, checks, debit, Visa, and MasterCard. There is a \$25.00 fee for returned checks to cover bank fees. We understand that on occasion, financial problems may affect timely payment of your account. If such a situation arises, please contact our office promptly so payment arrangements can be made.

Authorizations:

- I have read the above information and agree regardless of my insurance status to be responsible for the balance of my account. I agree to pay the co-pay, co-insurance, any remaining balance my insurance deems to be patient responsibility, and any fee for services rendered that are not covered by my insurance. I agree to notify this office should there be any change in my insurance coverage.
- I authorize the release of any medical or other information necessary to process any claims.
- I authorize payment of medical benefits to Evergreen Natural Health Center for all services rendered.

Patient's or Authorized Person's Signature:

Name (please print): _____

Signature: _____ Date: _____

Consent for Treatment: Naturopathy

General Diagnostic Procedures: Our practitioners may perform any of the following diagnostic procedures as necessary to provide proper assessment, determine treatment approach, and otherwise address your health concerns: including but not limited to general physical exam, gynecological exam, pap smear, blood, urine and saliva lab work, neurological and psychological assessments.

General Treatment Modalities: due to the diversity of Naturopathic medicine your treatment plan may include any of the following modalities:

- **Herbs/Natural Medicine:** prescribing of various therapeutic substances including plants, minerals and animal materials. Substances may be given as teas, pills, powders, tinctures (may contain alcohol); topical creams, pastes, washes, suppositories, or other forms. Homeopathic remedies may also be used.
- **Dietary Advice and Therapeutic Nutrition:** use of foods, diet plans or nutritional supplements for treatment- may include intramuscular injection of vitamins or minerals.
- **Counseling:** lifestyle counseling, stress management, exercise prescriptions and programs.
- **Soft Tissue Manipulation:** includes the use of massage, stretching, trigger point work, and craniosacral therapy.
- **Thermal Therapies:** hydrotherapy, use of alternation of warm to cold, infrared therapy.
- **Pharmaceuticals:** in some cases the physician may recommend a pharmaceutical medication within scope of practice.

Potential Risks: allergic reactions or side effects from herbs, supplements, or medications; pain or discomfort from manual therapies, hydrotherapy, or injection; aggravation of pre-existing symptoms.

Potential Benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: all female patients must alert the doctor if they know or suspect that they are pregnant, as some of the therapies used could present a risk to pregnancy.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me regarding cure or improvement.

Patient's Name (PRINT)

Patient's signature

Guardian/Representative name and authority (PRINT)

Guardian/Representative's signature (PRINT)