

Samantha L. Brody ND, LAc, PC
6610 SW Capitol Hwy. • Portland, OR 97239 • 503.977.0500
www.drdsamantha.com

Welcome to Our Clinic

Dr. Brody is licensed by the State of Oregon, and is trained as a physician and acupuncturist. Our goal is to provide the highest quality naturopathic and Chinese medical care available. Dr. Brody takes the time to develop an individualized treatment plan for each patient, treating the whole person and integrating all aspects of his or her health.

Dr. Brody's **office hours** are: Monday/Wednesday/Thursday 10 am - 6 pm

Front desk hours are: Monday/Wednesday/Thursday 9:30 am - 6:30 pm
Tuesday 2 pm - 6 pm
Friday 9 am - 1 pm

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

Other practitioners working out of our space:

Tracy Andersen LAc is available for acupuncture treatments and shiatsu massage on Monday/Wednesday 6pm-8pm, Tuesday 1pm-8pm, Friday 9pm-5pm, Saturday 11am-5pm, and other hours by arrangement.

Jennifer O'Leary ND is available for naturopathic visits Tuesday 2pm-7pm, Friday 9am-6pm, and other hours by arrangement.

Our hours 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.
- For Dr Brody, 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 Dr. Brody: *If you have a life threatening emergency, please call 9-1-1.*

If you need to reach the doctor, and leave a message on our machine or with one of our staff, Dr. Brody will do her best to return your call by the end of the next business day. If Dr. Brody 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.

Dr. Brody may also be available by email. Although only Dr. Brody has access to this email, 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.drdsamantha.com for additional information about Dr. Brody and our practice

Insurance & Financial Policies
PLEASE READ

Thank you for choosing us for your health care. If you have medical insurance that covers our services, we are happy to assist you in submitting your insurance claims. Co-pay or co-insurance is also due at the time of service.

Insurance:

In many cases we will be able to call to verify your coverage during your first visit. *If we are not able to verify coverage, payment in full is expected at the first visit.* If your insurance company remits payment you will be reimbursed.

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.

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. It is the patient's responsibility to follow up if a claim is not paid. We are happy to assist you with this process.

Supplements:

Most insurance companies do not cover supplements. Payment in full is expected at time of purchase. We are prohibited from accepting returns once a safety seal has been broken. There is no requirement to purchase recommended supplements from our office; there are several local stores that may carry similar products.

Late Cancellation/Missed Appointments:

As a courtesy to other patients requiring services, we request that you provide notice of cancellation 24 hours in advance of your appointment. **Patients who do not give 24 hour notice for a missed appointment will be charged a fee of \$50.00.** 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, 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.

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

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.

AND

• I authorize the release of any medical or other information necessary to process any claims.

AND

• I authorize payment of medical benefits to Samantha L. Brody ND, LAc, PC for all services rendered.

Patient's or Authorized Person's Signature:

Name (please print): _____

Signature: _____ Date: _____

Dr. Samantha Brody, ND, LAc, PC
6610 SW Capitol Hwy
Portland, Oregon 97239
(503) 977-0500

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 Samantha Brody ND, LAc, PC 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 judgement 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 is effective as of April 4, 2003. 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 you are a minor, or if you are being represented by another party, your representative signs below:

Personal Representative (please print) Personal Representative Signature

Date

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 _____

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Adult Intake Form

Patient Information:

Legal Name _____ Date _____

I prefer to be called: _____

Age _____ Date of birth _____ Gender F M

Occupation _____ Hours per week _____

How did you hear about our clinic? _____

Are you currently receiving health care? Y N

If yes, where, and from whom? _____

If no, when and where did you last receive medical or health care? _____

Medical History:

What are your most important health concerns, and is there anything else you would like to address?

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Medication History:					
aspirin	Y	N	P	antibiotics	Y N P
tylenol	Y	N	P	anti-histamine	Y N P
ibuprofen	Y	N	P	asthma meds	Y N P
sleep aids	Y	N	P	thyroid meds	Y N P
cortisone	Y	N	P	tranquilizers	Y N P
antacids	Y	N	P	laxatives	Y N P
decongestant		Y N P		inhalers	
topical steroids		Y N P		diet pills	
anti-depressants		Y N P		anti-epileptics	
Y N P		Y N P		Y N P	
other _____					
known allergies to medications:					

Please *specifically* list any prescription medications, over the counter medications, vitamins, or other supplements you are currently taking. Please attach page if necessary.

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

X-rays and Special Studies:			
EEG	Y	N	psychological evaluation
ECG/EKG	Y	N	reading/writing
x-ray	Y	N	CT scan
MRI	Y	N	other:
If any of the above are circled Y, please note reason for study:			

Injuries/Surgeries/Hospitalizations:

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

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Adult Intake Form

Immunizations:

Have you been immunized according to recommended CDC schedule?	Y N P
That you know of, are there any immunizations for which you are not current?	Y N
Any adverse reactions to immunizations? Y N (Please specify):	

Childhood Diseases (please circle those which you have had):

scarlet fever	mumps	measles	pneumonia	rubella	croup
chicken pox	other (s):				

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, **D= deceased:**

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

Review of Systems:

Although this section is lengthy, it assures that there is as much time as needed during the visit to address current concerns. It also allows the physician to make possible connections between symptoms that have not been noted before. Thank you for your patience.

Please circle: Y = a condition you have now, N = never had, P=have had in the past:

Mental/Emotional					
Mood Swings or Depression	Y	N	P	Eating Disorder	Y N P
History of counseling	Y	N	P	Anxiety or nervousness	Y N P
Considered/attempted suicide	Y	N	P	Tension	Y N P

Endocrine					
Thyroid problems	Y	N	P	Fatigue	Y N P
Low blood sugar	Y	N	P	Excess hunger or thirst	Y N P
Diagnosed diabetes	Y	N	P	Seasonal depression	Y N P
Heat or cold intolerance	Y	N	P	High blood sugar	

Immune					
Chronic Fatigue Syndrome	Y	N	P	Chronic infections	Y N P
Chronically swollen glands	Y	N	P	Autoimmune disease	Y N P
Slow wound healing	Y	N	P	Frequent colds	Y N P
Allergies or hayfever	Y	N	P		

Neurologic					
Seizures	Y	N	P	Paralysis	Y N P
Muscle weakness	Y	N	P	Vertigo or dizziness	Y N P
Loss of memory	Y	N	P	Numbness or tingling	Y N P
Loss of balance	Y	N	P		

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Skin							
Rashes	Y	N	P	Fungus	Y	N	P
Acne or boils	Y	N	P	Itching	Y	N	P
Color change	Y	N	P	Lumps	Y	N	P

Head							
Headaches	Y	N	P	Head injury	Y	N	P
Migraines	Y	N	P	Jaw/TMJ problems or clicks	Y	N	P

Eyes/Ears/Nose							
Floaters or 'spots'	Y	N	P	Double vision	Y	N	P
Tearing or Dryness	Y	N	P	Glaucoma or Cataracts	Y	N	P
Impaired vision/blurry vision	Y	N	P	Eye pain/strain	Y	N	P
Impaired hearing	Y	N	P	Earaches	Y	N	P
Ringling in ears	Y	N	P	Excess ear wax	Y	N	P
Stuffiness	Y	N	P	Sinus problems	Y	N	P
Hay fever	Y	N	P	Nose bleeds	Y	N	P
Loss of smell	Y	N	P	Post nasal drip	Y	N	P

Mouth and Throat							
Teeth grinding	Y	N	P	Frequent sore throat	Y	N	P
Gum problems	Y	N	P	Mouth sores	Y	N	P
Hoarseness	Y	N	P	Sore tongue or lips	Y	N	P
Dry mouth	Y	N	P	Excess Saliva	Y	N	P

Respiratory							
Cough	Y	N	P	Sputum	Y	N	P
Spitting up blood	Y	N	P	Wheezing or Asthma	Y	N	P
Pain on breathing	Y	N	P	Shortness of breath	Y	N	P

Urinary/ Kidney							
Pain on urination	Y	N	P	Infections	Y	N	P
Increased frequency	Y	N	P	Frequency at night	Y	N	P
Kidney stones	Y	N	P	Urine leakage	Y	N	P

Cardiovascular							
Heart disease	Y	N	P	Anemia	Y	N	P
Murmurs	Y	N	P	Phlebitis	Y	N	P
Blood clots	Y	N	P	Valvular problems	Y	N	P
Easy bruising	Y	N	P	Palpitations/fluttering	Y	N	P
Varicose veins	Y	N	P	Deep leg pain	Y	N	P
Swelling in ankles	Y	N	P	Poor circulation	Y	N	P
Chest pain	Y	N	P	Fainting	Y	N	P

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Gastrointestinal							
Trouble swallowing	Y	N	P	Belching or passing gas	Y	N	P
Liver disease	Y	N	P	Blood with stool or hemorrhoids	Y	N	P
Change in appetite or thirst	Y	N	P	Ulcer or black stools	Y	N	P
Heartburn or reflux	Y	N	P	Pain or Cramps	Y	N	P
Diarrhea	Y	N	P	Nausea or vomiting	Y	N	P
Gall Bladder disease	Y	N	P	Constipation	Y	N	P
Daily bowel movement?	Y	N	P	Is stool formed or loose or varied?			
If not daily, how often?				If daily, how many per day?			

Reproductive (male and female)							
Sexual orientation:				Sexually active with others?	Y	N	P
If you are sexually active, are you monogamous?					Y	N	P
Type of Birth control (if applicable):							
Discharge or sores	Y	N	P	Chlamydia	Y	N	P
Trouble conceiving	Y	N	P	Sexual Difficulties	Y	N	P
Low sex drive	Y	N	P	Genital warts	Y	N	P
Herpes	Y	N	P	Pain with sexual activity	Y	N	P
Male Only							
Hernias	Y	N	P	Testicular pain	Y	N	P
Prostate disease	Y	N	P	Testicular lumps or masses	Y	N	P
Female Only							
Age of first menses:				How many days of bleeding per cycle:			
Days from one period to next period:				Are cycles regular?	Y	N	P
PMS	Y	N	P	Bleeding between cycles	Y	N	P
Clotting	Y	N	P	Heavy cycles	Y	N	P
Painful menses	Y	N	P	Endometriosis	Y	N	P
Ovarian cysts	Y	N	P	Abnormal paps	Y	N	P
Menopause symptoms	Y	N	P	Breast lumps or pain	Y	N	P
Do you do self breast exams?	Y	N	P	Nipple discharge	Y	N	P
# pregnancies _____				# abortions _____			
				# miscarriages _____			
				# live births _____			
Have you had any children that were placed for adoption?							

Musculoskeletal											
Joint pain	Y	N	P	Arthritis	Y	N	P	Weakness	Y	N	P
Joint stiffness	Y	N	P	Broken bone	Y	N	P	Muscle pain	Y	N	P
Sciatica	Y	N	P	Osteoporosis	Y	N	P	Muscle spasm	Y	N	P

Other											
Chronic pain	Y	N	P	Lumps	Y	N	P	Cancer	Y	N	P
Any other condition not mentioned?											

