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

Samantha Brody ND, LAc, PC

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 relieve 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	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
sleep aids	Y N P	thyroid meds	Y N P	diet pills	Y N P
cortisone	Y N P	tranquilizers	Y N P	anti-depressants	Y N P
antacids	Y N P	laxatives	Y N P	anti-epileptics	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 evalulation	Y N
ECG/EKG	Y N	reading/writing	Y N
x-ray	Y N	CT scan	Y N
MRI	Y N	other:	
If any of the above are circled Y, please note reason for study:			

Injuries/Surgeries/Hospitalizations:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

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 the conditions you have: Y = PRESENTLY, N = NEVER HAD, P= 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 huger 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	Y N P

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
Tearning 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
Ringing 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 Y N P

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

Review of Systems: .

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Please circle the conditions you have: Y = PRESENTLY, N = NEVER HAD, P= HAD IN THE PAST

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
How often do you have a bowel movement (ex. Daily? Twice a week? Twice a day?) _______________________			
Is your stool formed (log) or loose (pile or liquid)? _______________________			

Reproductive (male and female)

Sexual orientation:		Are you currently sexually active?	Y N P
If you are sexually active, are you monogamous? Y N		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 _______ # miscarraiges _______ # live births _______			
Have you had any children that were placed for adoption? Y N			
Have you adopted any children? Y N If yes, how many? _______			

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?					

Lifestyle

Main interests and hobbies:			
Do you…			
exercise? If yes, what kind, and how often?			
have a spiritual practice,and if yes, what kind?			
sleep well?	Y N P	how many hours a night do you sleep?	
enjoy your work?	Y N P	eat three meals daily?	Y N P
Take vacations?	Y N P	read regularly?	Y N P
have a supportive relationship?	Y N P	have a history of abuse?	Y N P
use alcoholic beverages?	Y N P	use recreational drugs?	Y N P
use tobacco?	Y N P	have a history of addiction?	Y N P
Do you drink caffeine (cola, tea, coffee)? Which kind and how much?			
Are you happy with your weight? If no, how would you like it to change?			
Do you drink tap, bottled, or filtered water?			
How much water do you drink on a daily basis?			
Food intolerances (if known):			

A Few Final Questions :

1. How does your health affect your day to day life?

2. How would your life be different if you didn't have this condition(s)?

3. On a scale of 1-10, how committed are you to improving your state of health? _______

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

5. Is there anything else that you would like us to know about your medical history or your current health needs?

"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:_______________

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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)