

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 _____

Patient Intake: infant to 6 years

Patient Information:

Today's date: _____

Legal Name First: _____ Last: _____

You prefer child to be called: _____ Date of Birth: _____

Mother's name: _____

Father's name: _____

Sibling names and ages: _____

Pediatrician: _____

Clinic name and phone number: _____

Medication History:

Please list type and dosage of any prescription medications, over the counter medications, vitamins or other supplements you are taking. Please attach a list if necessary.

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

Known allergies to medications: _____

X-rays and Special Studies:

If your child has had any imaging studies (x-ray, ultra sound, MRI etc) or special testing done (hearing, reading, psych) please list test, approximate date, and outcome.

1. _____ 3. _____

2. _____ 4. _____

Injuries/Surgeries/Hospitalizations:

1. _____ 3. _____

2. _____ 4. _____

Immunizations:

___ measles ___ polio ___ MMR ___ small pox ___ diphtheria

___ mumps ___ DPT ___ tetanus ___ influenza ___ other: _____

Please note any adverse (bad) reactions to immunizations _____

Childhood Diseases:

___ chicken pox ___ rubella ___ mumps ___ measles ___ bronchitis

___ pneumonia ___ croup ___ scarlet fever ___ other(s) _____

Patient Intake: infant to 6 years

Medical History:

Currently, what are your child's most health concerns (why are you bringing him/her in)?

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

Please circle: Y = current condition, N = never had this condition, P = past condition

Eyes/Ears

Hives	Y	N	P	Burning of urine	Y	N	P
Eczema	Y	N	P	Frequent urination	Y	N	P
Allergies	Y	N	P	Bloody urine	Y	N	P
Nose bleeds	Y	N	P	Vomiting spells	Y	N	P
Bleeding gums	Y	N	P	Anemia	Y	N	P
High fevers	Y	N	P	Stomach aches	Y	N	P
Rash	Y	N	P	Jaundice	Y	N	P
Acne	Y	N	P	Easy bruising	Y	N	P
Mouth sores	Y	N	P	Diarrhea	Y	N	P
Sore throat / tonsillitis	Y	N	P	Constipation	Y	N	P
Frequent headaches	Y	N	P	Gas	Y	N	P
Frequent colds	Y	N	P	Easy bleeding or bruising	Y	N	P
Wheezing or asthma	Y	N	P	Joint pains	Y	N	P
Cough	Y	N	P	Dizzy spells	Y	N	P
Ear infections	Y	N	P	Motion/car sickness	Y	N	P
Unusual fears	Y	N	P	Change in appetite or weight	Y	N	P
Cries easily	Y	N	P	Heart murmur	Y	N	P
Nervous or anxious	Y	N	P	Flat feet	Y	N	P
Sleep problems	Y	N	P	Body/breath odor	Y	N	P
Night sweats	Y	N	P	Excessive fatigue	Y	N	P
Nightmares	Y	N	P	Behavioral problems	Y	N	P
Sensitive to light or sound	Y	N	P	Hair loss	Y	N	P

Any other condition/s not mentioned? _____

Patient Intake: infant to 6 years

Family Medical History: IF KNOWN. (If child or parents are adopted, please check here and inform doctor directly: _____) Please specify M=mother, F=father, S=sister, B=brother A=aunt, U=uncle, PGM or PGF=paternal grandparent, MGM or MGF=maternal grandparent

Allergies or hay fever _____	High Cholesterol _____
Arthritis _____	Cancer _____
Heart Attack/MI _____	Diabetes _____
High blood pressure _____	Other _____

Birth Mother's Prenatal History (if known):

Mother's age at child's birth _____

Any known problems regarding mother's health during pregnancy? **Y N**

Please note any particular psychological stress and drug, tobacco, or alcohol exposure as well as medical issues or complications of delivery. _____

A Few Final Questions:

1. How is your child's life affected by his/her state of health?

2. How would your child's life be different if he/she were experiencing optimal health?

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? _____

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

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)