A Family HEALING CENTER

829 NE HWY 99W
McMinnville, OR 97128
Phone: (503) 883-0333
Fax: (503) 503-857-0622

# Individual Patient Registration

MUST BE COMPLETED BY PARENT / GUARDIAN FOR MINOR (UNDER 18) PATIENTS

**PATIENT INTAKE INFORMATION:**

Patient Legal Name:_____ Preferred Name: _____

Date of Birth:_____Assigned Gender:_____Preferred Gender: _____

Email:_____

Address: _____

City: _____State: _____ Zip: _____

CELL Phone:_____ HOME Phone: _____

Primary Care Physician Name:_____ Phone Number:_____

Marital Status: _____ Social security Number: _____

Employer: _____ Employer Address: _____

**RESPONSIBLE PARTY INFORMATION / GUARDIAN (If different from above):**

Name: _____DOB: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Work Phone: _____

Employer: _____ Employer Address_____

**INSURANCE INFORMATION:**

**If you would like your insurance billed for you, the following information must be complete.**

Primary Insurance Company: _____ Insurance Address: _____

Employer: _____Employer Address: _____

Subscriber's Name: _____ Date of birth: _____

Member/Policy Number: _____ Group Number: _____

Does your coverage include Naturopathic Care? ____ Y ____ N Out of Network Benefits: ____Y _____ N?

Is your condition the results of an accident (car accident, work, fall, etc.) _____ Y _____ N?

**Emergency Information: Person(s) to contact in case of emergency:**

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____



Patient Initial: _____ Date: _____

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**DEMOGRAPHICS:**

| Race: | Ethnicity: | Preferred Language |
|---|---|---|
| __ Decline | __ Decline | __ Decline |
| __ American Indian or Alaska Native | __ Hispanic | __ English |
| __ Asian | __ Latino | __ Spanish |
| __ African American | __ Not Hispanic/Latino | __ Other: _____ |
| __ White | __ Other: _____ | |
| __ Other: _____ | | |

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have been given A Family Healing Center, Notice of Privacy Practices*. I understand that if I have questions or complaints, I may contact the Facility Privacy Official. * Available at check-in, online at www.afamilyhealingcenter.com or through the patient portal.

**DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO PATIENTS FAMILY OR OTHERS**

Under the Health Insurance Portability and Accountability Act of 1996, as amended, patients have the right to agree, restrict or object to providing PHI to family members or other person identified as involved in the patient's care or payment for the patient's healthcare. To comply with the regulations, as outlined in our facility policies, documentation of the patient's wishes must be present in the medical record.

**I am granting permission for A Family Healing Center to release PHI concerning myself to:**

Name:_____ DOB:_____ Relationship:_____

Name:_____ DOB:_____ Relationship:_____

Name: _____ DOB: _____ Relationship: _____

**MEDICATION HISTORY NOTICE ACKNOWLEDGEMENT**

I understand that A Family Healing Center (AFHC) may need access to my medication history and may work in conjunction with my pharmacy and / or insurance carrier to provide accurate medical treatment. AFHC has permission to contact them as needed for this purpose.

Patient Name: _____

Patient Signature: _____

Date: _____

Preferred Pharmacy: _____

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## PATIENT PORTAL, EMAIL & TEXT MESSAGING COMMUNICATION NOTICE ACKNOWLEDGEMENT

Our clinic requires patients to provide a valid email address for access to our Patient Portal, to assist the Clinic to in complying with Federal "Meaningful Use" Requirements, and for communication that may contain "Protected Health Information". Patient acknowledges that all Patient Appointments and Care Documents will be made available on their Patient Portal for all Encounters after September 15, 2016, and agrees to access their Portal for this information. Please also understand that records are held for 7 years. When referred to another provider, A Family Healing Center does share PHI with the referring provider.

The Practice will use reasonable means to protect the security and confidentiality of e-mail and text messaging information sent and received. Patient agrees that A Family Healing Center may utilize email correspondence for all healthcare related billing matters, including sending emails that contain PHI (Protected Health Information) and billing information which may contain Clinic billing statements, Explanation of Benefits and Explanation of Payments received from your insurance, and any other documents related to your healthcare and billing documentation. The Practice cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper use and/or disclosure of confidential information (including Protected Health Information that is the subject of the federal Health Insurance Portability and Accountability Act of 1996) that is not caused by the Practice's intentional misconduct.

**Patient Email Address to Receive Clinical Correspondence:** _____

I acknowledge that I have read and fully understand the information the Practice has provided me regarding the risks of using e-mail. Patient Initials:_____Date Initialed:_____

My signature below indicates that I have been given the chance to read and review the following and understand and agree to their terms:

- Financial Policy, Consent for Treatment and Release of Medical information
- Patient Portal, Email & Text Messaging Communication Notice Acknowledgment
- Patient Acknowledgment Agreement
- HIPAA Notice of Privacy Practices Patient Acknowledgment Form

I agree that the above information is true and I authorize A Family Healing Center to use this information to obtain financial reimbursement. Additionally, I authorize A Family Healing Center to administer treatment and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to A Family Healing Center. In the event my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. This authorization is to remain in full force unless I revoke the same in writing.

Patient Name: _____

Patient Signature: _____

Date: _____

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# HIPAA NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT FORM

I understand that the patient's health information is private and confidential. I understand that A Family Healing Center works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information. A Family Healing Center displays a copy of their "NOTICE OF PRIVACY PRACTICES" at our front desk, on your patient portal, and on our website, www.AFamilyHealingCenter.com

Patient Name: _____

Patient Signature: _____

Date: _____

## Financial Policy, Consent for Treatment, Release of Medical Information

Thank you for choosing A Family Healing Center as your health care provider.

**You and your insurance carrier are responsible for your bill.**
**Knowing our insurance plan benefits is your responsibility.**

The following are the financial terms of this office. Your signature below signifies your acceptance of these terms as a condition of the services rendered and your receipt of a copy of this agreement. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. To achieve these goals, we need your assistance and your understanding of our financial policy. You are ultimately responsible for all clinic fees relating to your care. You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates. Your insurance policy is a contract between you and your insurance company. Any disagreement you have concerning the amount your insurance pays should be directed to your insurance company

**Insurance information must be presented/updated at the time of making your appointment** not at the time of service. Most insurance companies have requirements for authorization of services and/or referrals from the Primary Care Provider prior to the services. If you present for your appointment and you have not provided your correct insurance to ensure verification, authorization of services and all required referrals, you will not be seen and your appointment will be rescheduled. Copayments, co-insurance and deductibles for services are required at the time of service. Please be advised that we are contractually obligated by your insurance carrier to collect your co-payment, coinsurance and deductible at the time of service.

**For services that are not covered by insurance**, the practice requires payment of 100% of the total estimated charges unless prior payment arrangements have been set up with our office.

**Medicare:** We are unable to bill Medicare or order any test or lab work to be billed to Medicare. If you have Medicare you will be a self-pay patient for any office visits, tests or labs by our doctors.

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**Self-Pay and Insured individuals electing to be self-pay**. The patient may elect not to file their health insurance and elect to be a self-pay patient for services provided IF THE INSURANCE COMPANY IS OUT OF NETWORK. The patient will be financially responsible for charges incurred and payment will be due at the time of service. After services have been rendered, the patient will not be able to file their health insurance for the services due to insurance claim submission requirements. A Family Healing Center will not file insurance for any services where the patient elected to be self-pay. The patient 's election to not file the services to their insurance company does not affect or reduce any out of pocket financial responsibility for future services as determined by their insurance plan. **Your charges are due in full at the time of service in which you will receive a 20% discount.**

**Out of Network Insurance**- Some insurance plans require you to pay different out-of- pocket amounts based on the provider and/or location where the service is performed. Deductibles, co-insurance and co- payments may also apply according to your insurance plan. By law, you are responsible for these amounts, as well as any non-covered services outlined in your health plan. It is your responsibility to inquire about any plan specific coverage limitations with your insurance company. You can choose to have the services performed as "Out of Network" or as self-pay.

**Late Payment and Collection Fees:** You agree to pay the higher of a minimum $30 monthly late payment fee or up to a 3% monthly compounded interest on all unpaid charges that are not paid within 45 days of the encounter date. If your account is turned to a collection agency a 40% add-on fee will be applied. You agree to pay all reasonable Collection, Court and Attorney's Fees we incur in the collection of your debt. These accounts may be reviewed for assignment to an outside collection agency for collection. If legal action is taken to collect any amounts owed, the prevailing party shall be entitled to recover their reasonable attorney fees. Past due accounts may be considered closed without further notice. We reserve the right to decline to provide any further services until the closed account is paid in full or appropriate payment arrangements are made.

**Returned Payment,Credit and Debit Card Charges** are subject to a handling fee of $36.00 per occurrence plus card processer charge-back charges. Any payments charged back to us by patients will also incur the charge in addition to any fees charged by your or our credit/debit card processor. Our receipt of this fee notice is the only notice we need to receive, the charges will be placed on your statement, and future appointments will be cancelled until fees are paid.

**Multiple Accounts:** We reserve the right to apply overpayments from one account to a remaining balance on another account with the same guarantor. According to Oregon law, a spouse is financially responsible for family expenses incurred by the other spouse or for the benefit of their minor children or stepchildren. It is agreed that all charges incurred or fees imposed according to this agreement are family expenses for which both spouses/parents are financially responsible.

**Communication Consent:** You agree, in order to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers. We may also contact you by sending emails, using any email address you provide to us. Methods of contact may include using automated messages and/or use of automatic dialing. Your consent to these communications applies to those communications initiated by our office or by an agent, attorney, or collection agency acting on our behalf.
**Procedures for No Shows, Late Arrivals resulting in Appointment Cancellation and Late Patient Cancellations. After missing 3 appointments (due to No Show, Late Arrival or Late Cancellations) are subject to dismissal from A Family Healing Center.**

**Late Arrival to Appointments Defined:** We make every attempt to stay on schedule, to help us please be on time. Your appointment will be cancelled if you are 15 minutes late.

**Fees We Charge for No Shows, Late Arrivals resulting in Appointment Cancellation and Late Patient Cancellations.**
You agree that there will be a:

- $115.00 charge for new patient appointments, and a $50 fee for returning patient appointments
- All future appointments will be cancelled and will not be rescheduled until payment of No Show, Late Arrival and Late Patient Cancellation fees are made.

**Appointment Cancellation**: Please call 24 business hours in advance to cancel an appointment. If you do not call to cancel, you will be billed a $50 cancellation/no show fee for return patients and $115 for new patients. If you provide a credit card upon scheduling, it will be billed the same day the appointment is missed.

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**Medicinal Returns:** We are unable to give refunds or credits on tinctures, gemmos, or homeopathics; opened or unopened. By law, A Family Healing Center cannot re-sell these un-sealed products.

**Litigation:** Patients involved in law suits are responsible for timely payments of charges incurred. We require monthly payments to be made by the patient.

**Personal Hygiene:** For health considerations and due to the close interpersonal nature of our work, your personal cleanliness is required for a comfortable environment. NO SMOKING or other strong aromatics please.

**Accordingly (Initial each statement):**

_____ I have read and understand the notice of privacy policies of A Family Healing Center.

_____ I understand that insurance may not cover certain diagnostic tests, procedures, IV Therapy, or supplements that may be prescribed by the doctor and I agree to pay for these costs at the time of visit. This would be discussed with your pitot to the treatment being administered.

_____ I have read the policies above and agree to be financially responsible for services provided by this office.

## AUTHORIZATION:

I hereby authorize A Family Healing Center to administer treatment, diagnostic testing and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to A Family Healing Center. In the event my insurance makes payment directly to me for services I will immediately endorse and assign the payment to A Family Healing Center. If my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. I give A Family Healing Center permission to appeal any denials by my insurance for services rendered on my behalf. I will assist A Family Healing Center with follow up of timely payment, requests for information and appeals to my insurance as necessary to ensure full and timely payment for services received. I further agree that a photocopy of this agreement shall be as valid as the original.

## PATIENT ACKNOWLEDGEMENT OF AGREEMENT:

I have read the A Family Healing Center Financial Policy and Consent for Treatment, policy and understand and agree to its terms. This authorization is to remain in full force unless I revoke the same in writing.

**If the patient is a minor, permission is given by me to the doctors of this office to treat my child.**

Patient Name: _____

Patient Signature: _____

Date: _____

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# HEALTH HISTORY

Patient Name :_____ Birthdate : ___/_____/____ Todays date: _____

Primary care physician: _____
Please list all medicines you are currently taking (including non-prescription drugs): _____
_____
_____
_____
_____

**Goals for Treatment**
Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:
_____

**Past Medical History** such as cancer, diabetes, ear infections, eczema, accidents, injuries, mono infection surgeries, organ removals, etc…(please list dates of occurrences)
_____
_____
_____

**Family History** such as cancer, diabetes, heart disease, stroke, migraines, mental illness, or autoimmune condition (please state who in the family had these conditions)
_____
_____
_____

Habits such as alcohol, coffee, smoking, etc… _____
Exercise: _____

**MEN ONLY:** circle "yes" or "no" or leave blank
Urination changes or difficulties….yes no Night urination....yes no Sexual dysfunction….yes no

**WOMEN ONLY:** circle "yes" or "no" or leave blank
**Do you plan on getting pregnant in the next year?**
**Do you currently use birth control? Yes No, if yes which type: Pill, IUD, Implant, Injection, Other _____**
Problems with menstrual cycle…Yes No, If yes:_____
Vaginal itching or discharge…Yes No Numbers of pregnancies: _____ Live births:_____
Hot flashes or night sweats…Yes No If yes, how many per day? _____

To the best of my knowledge, the above information is correct. I understand that giving inaccurate information may harm my (my child's) health. It is my responsibility to inform the doctor of any changes in my or my child's medical status.
I authorize the health care staff to perform necessary health care services.

Patient's signature: _____