NEW PATIENT INTAKE FORM

Full Name: _____ Date of Birth: ___/___/___ Today's date: ___/___/___

Age: _____ Female ❒ Male ❒ Other ❒ E-mail: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Okay to Leave Detailed and/or Text Message at: Home ❒ Work ❒ On my Cell ❒

Single ❒ Married ❒ Separated ❒ Other ❒

Emergency Contact Name & Phone Number: _____

Occupation: _____ Religious Affiliation (Optional): _____

Hobbies: _____

Primary Care Physician: _____ Okay to contact: Yes ❒ No ❒

Referred by: _____ May we thank them: Yes ❒ No ❒

HEALTH INSURANCE INFORMATION

Primary Insurance: _____ Naturopathic Coverage: Yes ❒ No ❒ I don't know ❒

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____/_____/_____

Policy Holder's Employer: _____ Co-payment for Office Visits: $_____

*We check insurance benefits as a courtesy to our patients, but **we do not guarantee insurance coverage**.*

OFFICE POLICIES

CANCELLATION POLICY: Last minute cancellations of scheduled appointments are challenging to fill and may waste an opportunity for another patient in need. Due to both community demand and undo cost to the clinic, we therefore **require changes or cancellations to be made at least 24 hours prior to the scheduled appointment.** For missed appointments or cancellations made less than 24 hours before the scheduled appointment, you will be charged $50.00 for the first missed visit and $100.00 for any subsequent missed visits.

RETURN POLICY: **We do not accept any returns or exchanges** on any product or service sold or provided to you by Baker Family Naturopathic.

I, the patient, understand that I will be charged for any appointment missed or cancelled less than 24 hours in advance. I hereby agree to pay any and all charges. Additionally, I understand that Baker Family Naturopathic will not accept any returns or exchanges as mentioned above.

Signature: _____ Today's Date: _____/_____/_____

Relationship to patient: _____

PATIENT HEALTH HISTORY **Patient Name:**_____

Allergies to Medications: _____

Current Medications: _____

Current Supplements: _____

Most Important Health Concerns: _____

Reason for Today's Visit: _____

FAMILY HISTORY

Disease	*Yes*	*No*	*Which Relative(s)*	*Deceased/Living*
Breast Cancer	Y ❒	N ❒		
Other Cancer	Y ❒	N ❒		
Diabetes	Y ❒	N ❒		
High Blood Pressure	Y ❒	N ❒		
Heart Disease/Stroke	Y ❒	N ❒		
Kidney Disease	Y ❒	N ❒		
Liver Disease	Y ❒	N ❒		
Blood Disorder	Y ❒	N ❒		
Mental Illness	Y ❒	N ❒		
Alcoholism/Drug Abuse	Y ❒	N ❒		
Thyroid Issues	Y ❒	N ❒		
Cataracts/Glaucoma	Y ❒	N ❒		
Osteoporosis	Y ❒	N ❒		

Other: _____

PERSONAL HISTORY

Major Illnesses (type & when): _____

Surgeries/Hospitalizations/Accidents (type & date): _____

Major Toxic Exposure: Pesticides/Chemicals _____ Heavy Metals _____

Have *YOU* Ever Experienced: Check Yes or No, and ***please circle which condition if yes.***

Y ❒	N ❒	Measles/Mumps/Rubella/Chicken Pox/Mono/Strep	Y ❒	N ❒	Headaches/Numbness/Sensory Change/Head Injury
Y ❒	N ❒	Liver Disease/Hepatitis/Jaundice	Y ❒	N ❒	Epilepsy/Loss of Consciousness
Y ❒	N ❒	Gallbladder Disease/Gallbladder Stones	Y ❒	N ❒	Fatigue/Insomnia/Waking Not Rested
Y ❒	N ❒	Kidney Disease/Urinary Problems/Bladder Infections	Y ❒	N ❒	Poor Memory/Confusion/Foggy Mind
Y ❒	N ❒	Gonorrhea/Chlamydia/Herpes/ Genital Warts/Other Sexually Transmitted Disease	Y ❒	N ❒	Anemia/Nose Bleeds/Easy Bruising
Y ❒	N ❒	Pain/Impotence/Problems with Sexual Intercourse	Y ❒	N ❒	Hot Flashes/Night Sweats
Y ❒	N ❒	Ovarian/Uterine/Testicular Pain, Problems, or Masses	Y ❒	N ❒	Thyroid/Pituitary/Adrenal Problems

Patient Name:_____

Y ❒	N ❒	Lung Disease/Shortness of Breath/Asthma/Tuberculosis	Y ❒	N ❒	Weight Loss/Gain (>10 Lbs.)
Y ❒	N ❒	Racing Heart/Chest Pain/High Cholesterol/Hypertension	Y ❒	N ❒	Sinus Problems/Runny Nose/Allergies
Y ❒	N ❒	Muscle Cramps/Tightness/Aches	Y ❒	N ❒	Recurrent Colds/Flues/Infections
Y ❒	N ❒	Visual Changes/Eye Pain Infections/Cataracts	Y ❒	N ❒	Cancer/Pre-Cancer of Any Kind
Y ❒	N ❒	Ear Pain/Ear Infections/Decreased Hearing/Ringing	Y ❒	N ❒	Skip Meals/Dieting/Binge Eating
Y ❒	N ❒	Joint Pain/Arthritis/Bone Loss/Bone Pain	Y ❒	N ❒	Diabetes/Hypoglycemia/Sugar Craving
Y ❒	N ❒	Digestive Troubles/Pain/Gas/ Bloating/Constipation/Diarrhea	Y ❒	N ❒	Depression/Anxiety/Irritability/ Weepiness
Y ❒	N ❒	Itching/Rashes/Eczema/Psoriasis/ Mole Changes	Y ❒	N ❒	Dry Skin/Excessive Sweating/ Hair loss

Other Health Problems/Concerns: _____

SOCIAL HISTORY

Exercise # of days/week:_____ type(s):_____

Caffeine (# cups/day): Coffee_____ Tea_____ Soft Drinks_____

Nicotine Use: Y ❒ N ❒ In the past ❒ # of cigarettes/day:_____total years smoking:_____

Alcohol Use: Y ❒ N ❒ In the past ❒ # of drinks_____ per day ❒ week ❒ month ❒

Drug Use: Y ❒ N ❒ In the past ❒ Type(s):_____

Use: daily ❒ weekly ❒ monthly ❒ almost never ❒

Sexually Active: Y ❒ N ❒ Prefer: Men ❒ Women ❒ Both ❒ Practice Safe Sex? Y ❒ N ❒

History of Sexual/Physical/Emotional Abuse: Y ❒ N❒ _____

Currently Live With: _____

OB/GYN HISTORY (*Women Only*)

Age at 1st menses:_____ First day of Last Period:_____ Periods Regular: Y ❒ N ❒

Currently pregnant: Yes ❒ No ❒ Maybe ❒ Are you trying to get pregnant: Y ❒ N ❒

Birth Control Method:_____ Are you satisfied with this method: Y ❒ N ❒

Last Annual Exam:_____ Abnormal Pap Smear Ever: Y ❒ N ❒

Total Number of Pregnancies:_____ # Births:_____ # Miscarriages:_____ # Abortions:_____

Number of Children Breast Fed: _____ Total # Years on Hormones (including birth control):_____

Last Mammogram: _____ Abnormal Mammogram Ever: Y ❒ N ❒

Gyn and/or Breast Surgeries & Dates:_____

Question/Concerns:_____

I look forward to assisting you with your health!

INFORMED CONSENT TO TREATMENT

Patient Full Name:_____ Date of Birth: _____ /_____ /_____

This is to acknowledge that I have been informed and understand that:

1. As Naturopathic Physician, Dr. Emma Baker does not have hospital privileges and can only prescribe certain drugs. Therefore, I, the patient, may maintain an on-going relationship with a local primary care (M.D. or D.O.) physician of my choosing.

2. **In the case of a medical emergency, I, the patient, am to call 911 or proceed to the nearest emergency room.**

3. I, the patient, understand that Dr. Emma Baker offers **adjunctive care only to cancer patients**. I will therefore maintain care with an M.D. or D.O. oncologist of my choosing should I be diagnosed with cancer.

4. Any treatment or advice provided to me as a patient of Dr. Emma Baker is not mutually exclusive from any other treatment or advice that I may be receiving now or in the future from another healthcare provider.

5. I, the patient, am at liberty to seek or continue medical care from any physician, surgeon, or other healthcare provider.

6. The treatment and therapies provided or recommended by Baker Family Naturopathic may be different than those usually offered by other licensed healthcare providers.

7. There have not been any representations made regarding the likelihood of success of any recommendation(s) or treatment(s) offered.

I hereby authorize and consent to treatment.

Signature: _____ Today's Date: _____ /_____ /_____

Relationship to Patient: _____

Witness Signature: _____ Today's Date: _____ /_____ /_____

NOTICE OF PRIVACY PRACTICES AKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that the information can and will be used to:

- Conduct, plan and direct my course of treatment
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read, and understand Baker Family Naturopathic Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that Baker Family Naturopathic has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my PHI is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions in writing.

Patient Full Name: _____

Signature: _____ Today's Date: _____ /_____ /_____

Relationship to Patient: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Initials: _____ Date: _____ /_____ /_____

Reason: _____

_____

ADVANCED BENEFICIARY NOTICE (ABN)

Patient Full Name:_____ Date of Birth: _____ /_____ /_____

The purpose of this notice is to help you make an informed decision about whether or not you want to receive these items and/or services, fully knowledgeable that you might have to pay for them out of pocket.

I, the patient, accept that **my insurance company may or may not pay** for the items and/or services provided by Baker Family Naturopathic should they become necessary in my course of treatment:

1. Naturopathic Office Visits and Exams
2. Bowen Therapy
3. Massage
4. Nutritional and/or herbal supplements
5. Injectables and Injections
6. Any service ordered by a Naturopathic physician (including labs, imaging or any other service(s))
7. Telemedicine and/or phone visits

Before you make a decision about your options, you should read this entire notice carefully. If you do not understand why your insurance may not pay, ask us to explain. Ask us how much these items and/or services will cost in case you have to pay for them out of pocket.

Please choose **ONE** of the following options:

☐ Option 1: **YES**, I want to receive these items and/or services should they become necessary.

I, the patient, understand that my insurance will not decide whether to pay unless I receive these items and/or services and have a claim submitted. **I understand you may bill me for these items and/or services in full if my insurance denies my claim and refuses to pay within 45 days of the submitted claim. I agree to be personally and 100% financially responsible for payment.**

☐ Option 2: **NO**, I do not want to receive these items and/or services

I will not receive these items or services. I understand that you will not be able to send a claim to my insurance.

☐ Option 3: **YES**, I want to receive these items and/or services

I will receive these items or services, **but I choose to pay by cash, check, or credit card in full at the time of service**.

Signature: _____ Today's Date: _____ /_____ /_____

Relationship to Patient: _____

ACKNOWLEDGEMENT OF DISCLOSURE AND ACCEPTANCE OF PATIENT FINANCIAL RESPONSIBILITY

Patient Full Name:_____ Date of Birth: _____ /_____ /_____

Please Initial the following:

_____ I, the patient, understand that my **copay and/or deductible is due at the time service is rendered**.

_____ I, the patient, understand that all fees are due at the time service is rendered, that **all sales on any products or services are final**, and that Baker Family Naturopathic cannot provide refunds nor exchanges.

_____ I, the patient, authorize Baker Family Naturopathic to bill my health insurance, if applicable, for services rendered.

_____ I, the patient, understand that my **insurance agreement is between me and my insurance company** and that Baker Family Naturopathic does not promise that my insurance company will pay the charges for my services rendered. If my insurance company denies payment, I, the patient, am 100% responsible for payment.

_____ I, the patient, understand if my insurance company does not pay my claim within **30 days**, and BFN is not notified by the insurance company of delayed payment, **then it is my responsibility as the patient to contact my insurance to expedite payment**

_____ I, the patient, understand if my insurance company does not pay within **45 days**, then I, the patient, am **required to pay the balance on my account** in the form of cash, check, Visa, or MasterCard.

_____ I, the patient, understand that there is a $45 returned check fee, when applicable.

_____ I, the patient, understand that I personally, not my insurance company, will be charged for any appointments missed or cancelled less than **24 hours in advance**.

_____ I, the patient, understand that if I am late on making a payment, I may be charged a fee after 60 days, and if my **account balance is overdue by 90 days** then I will be **taken to collections** and a **200% collections fee** will be added to account balance.

_____ I, the patient, understand that in accordance with Oregon trade regulation 646.639 section n, I agree to pay all collection costs, interest, attorney fees and any other charges arising out of this account should Baker Family Naturopathic place any outstanding indebtedness that has been due to a collection of any debt I owe Baker Family Naturopathic. It is further understood that should my outstanding account be placed with a collection agency that the amount I owe **will be doubled** to cover the cost of collection. In addition, I understand that I will be liable for all court costs and attorney fees.

I, the patient or the patient's legal representative, hereby agree to pay any and all charges as listed above.

Signature: _____ Today's Date: _____ /_____ /_____

Relationship to Patient: _____