Oregon Naturopathic Clinic
Kimberly Foster ND
1278 Arcadia Dr. Eugene Oregon 97401
541-221-1827
www.oregonnaturopathicclinic.com
www.facebook.com/oregonnaturopathicclinic
www.twitter.com/OregonNatural

PATIENT REGISTRATION

Date _____

First Name_____ Middle Initial ____ Last Name_____
Date of Birth _____Age _____ F__ M__ Soc. Sec.#_____
Address _____ Home Phone_____
City _____ State_____ Zip _____Cell Phone _____
Employer _____ Occupation _____ Work Phone _____
Number where we can leave a confidential Voicemail_____
Marital Status: S M W D P Spouse's Name _____ # of Children_____
Emergency Contact (name & phone): _____
I am here today due to: Illness __ Trauma __ Work Injury __ Auto Accident __ Other __
What date did this occur? _____
How did you hear about Oregon Naturopathic Clinic? _____

FOR INSURED PATIENTS ONLY

PRIMARY INSURANCE: Private Ins. ___ Auto ___ WC___
Ins. Co. & Address: _____
Name of Insured: _____ ID No: _____
Group No. _____ Claim No._____

SECONDARY INSURANCE: Private Ins. ___ Auto ___ WC___
Ins. Co. & Address: _____
Name of Insured: _____ ID No: _____
Group No. _____ Claim No._____

I understand that health insurance policies are an arrangement between my insurance carrier and myself. Billing is done by the Oregon Naturopathic Clinic as a courtesy only and all services rendered to me are my personal responsibility. I authorize the release of any medical information necessary to process my insurance claim and I authorize payment of medical benefits to this office for professional services rendered.

Patient or Guardian Signature_____ Date_____

If Guardian, relationship to patient_____

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CONSENT FOR TREATMENT

I hereby authorize Kimberly Foster, Naturopathic Physician, to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

General Diagnostic Procedures: Including but not limited to performing physical exams, ordering and interpreting laboratory work and diagnostic imaging.
Alternative Diagnostic Procedures: Including but not limited to muscle response testing, alternative laboratory work and imaging.
Minor Office Procedures: Including but not limited to ear wax removal, skin tag removal, and wart removal.
Medical Use of Nutrition: Including but not limited to therapeutic nutrition, nutritional supplementation, intramuscular vitamin injections and IV therapy.
Botanical Medicine: botanical substances may be prescribed as teas, alcoholic tinctures, glycerine tinctures, capsules, tablets, cremes, plasters, or suppositories.
Homeopathic Medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.
Counseling, Exercise and Hygiene Prescriptions: general counseling, risk reduction counseling, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
Supplement Prescriptions: Including but not limited to herbal, homeopathic, vitamin, and mineral supplementation.
Medication Prescriptions:
Naturopathic Physical Medicine: including but not limited to massage, muscle energy stretching, visceral manipulation, cranial sacral therapy, NMT, and manipulations of the extremities and spine.
Electromagnetic and Thermal Therapies: Including but not limited to ultrasound, and electric stimulation of muscles.

Potential Risks: Allergic reactions and side effects to prescribed herbs, supplements or medications. Injuries from injections or physical medicine.

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, since some of the therapies used could present a risk to the pregnancy.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in any of these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Kimberly Foster, Naturopathic Physician, I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

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Patient Health History

Date_____

First Name_____ Middle Initial ____ Last Name_____
Birth Date_____
Primary Care Physician: Name_____ Number_____
Preferred Pharmacy Name_____ Number_____

List Current Supplements_____
_____
List Prescribed Medications_____
_____
List Over the Counter Medications_____
Allergies/Sensitivities_____
_____
Caffeine/Alcohol/Drug/Tobacco use (type, quantity, and frequency) _____
_____
_____
Exercise (type and frequency) _____
Describe Your Usual Diet_____
_____
Hospitalizations (date and reason) _____
_____
Diagnosed Medical Conditions_____
_____
Health Complaints/Concerns/Symptoms_____
_____
_____
_____
Family Diagnosed Medical Conditions_____
_____

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Payment Policy

We require payment at the time of service. If you have private health insurance and we are billing them,
you pay only your co-pay or co-insurance at the time of service (you must first meet the yearly deductible your insurance policy specifies).

In the case of personal injury (auto accident) and workers' compensation claims, we will bill the entire amount of each visit to your insurance company. ***If your insurance company is not paying, or stops paying, you will have to pay for appointments in full at the time of service. You will be issued a refund at the time we receive payment from your insurance company.*** The cost of supplies, supports or supplements not paid for by your insurance are your responsibility and we will ask you to pay for them once we've heard back from your insurance company.

If payment for any part of your treatment is denied by an insurance carrier you will assume full responsibility for payment and will pay independent of any appeal process with the insurance carrier to the extent allowed by law.

Cancellation Policy

We require **24 hours** notice for all cancellations. If you cancel with less than 24 hours notice, you will be charged 50% of the total charges for the visit. If you fail to keep your appointment and do not call to cancel, you will be charged IN FULL for the total visit.

I have read, understand and agree to the above payment and cancellation policies while utilizing the services of the Oregon Naturopathic Clinic.

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Electronic Communication Consent

By signing below I am consenting to receive communications by email from Oregon Naturopathic Clinic. I acknowledge I have been informed of the inherent risks of emailing and have received a copy of Oregon Naturopathic Clinic's **Electronic Communication Policy**. I agree to abide by the patient responsibility requirements in this policy.

Patient or Guardian Signature_____ Date_____

If Guardian, relationship to patient_____

Email Address _____

(Please note that if you do not sign your consent on this form and email us anyways you have implied consent for us to communicate to you by email.)

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

By signing below I acknowledge I have received a copy of Oregon Naturopathic Clinic's **HIPPA Notice of Privacy Practices** and I have been provided an opportunity to review it.

Patient or Guardian Signature_____ Date_____

If Guardian, relationship to patient_____