



**Methods of communication :**

Salem Natural Medicine or individual health care providers will call patients at times, and we wish to ensure your privacy regarding treatment at our clinic. In the event that we are unable to reach you by phone, please **indicate where it is appropriate to leave messages for you (no personal health information will be disclosed):**

Home message machine     With family members     At work     Never leave messages

Please contact me at the following telephone number: \_\_\_\_\_

Note: Appointment reminders are sent via Email.

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**How did you hear about our clinic?** \_\_\_\_\_

**What are your primary health concerns? List as many as you can, in the order of their importance to you.**

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

**What are the primary expectations you have for your visit today to our clinic?**

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

**Is this your first visit to a Naturopathic Physician?** \_\_\_\_\_

**Are you currently receiving health care? If yes, where and from whom? Please provide contact information (phone and address) if available. If not, when did you last visit a doctor's office, medical clinic, or hospital and why?**

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## Self History

### General

Height: \_\_\_\_\_ Weight: \_\_\_\_\_. Weight 1 year ago: \_\_\_\_\_ Maximum weight: \_\_\_\_\_ When: \_\_\_\_\_

When during the day is your energy best? \_\_\_\_\_ Worst? \_\_\_\_\_ Blood Type? \_\_\_\_\_

Primary interests and hobbies? \_\_\_\_\_

Type(s) of exercise? \_\_\_\_\_

How often and How long? \_\_\_\_\_

### Assessing the Areas of Your Life

In assessing your health, it is helpful to have some sense of the degree of satisfaction you feel in various areas of your life. Using the scales below, please rate yourself in terms of satisfaction and dissatisfaction. Number 1 means you are very dissatisfied or stressed. Number 10 means you are very satisfied or comfortable.

#### *Friends & Family*

0 1 2 3 4 5 6 7 8 9 10

#### *Physical Environment*

0 1 2 3 4 5 6 7 8 9 10

#### *Health*

0 1 2 3 4 5 6 7 8 9 10

#### *Career*

0 1 2 3 4 5 6 7 8 9 10

#### *Relationships/Romance*

0 1 2 3 4 5 6 7 8 9 10

#### *Recreation*

0 1 2 3 4 5 6 7 8 9 10

#### *Money*

0 1 2 3 4 5 6 7 8 9 10

#### *Personal Growth/Spirituality*

0 1 2 3 4 5 6 7 8 9 10

**Check the appropriate box:**

	Yes	No
In a supportive relationship		
History of abuse		
Have you had any major traumas		
Use recreational drugs		
Had drug/alcohol treatment		
Drink alcohol? Beer/ Wine/ Spirits. How many drinks daily: _____		
Ever feel you should cut down on drinking alcohol		
Have people annoyed you by criticizing your drinking		
Felt bad/ guilty about drinking		
Ever have an eye-opener		
Use tobacco? How many packs daily: ____ How many years: ____		

	Yes	No
Enjoy your work?		
Take vacations		
Spend time outside		
Watch TV? Hours daily ____		
Read? Hours daily ____		
Eat 3 meals daily		
Go on diets more than twice yearly		
Drink black tea? How much daily _____		
Drink coffee? How much daily _____		
Drink soda or energy drinks		
Use artificial sweeteners		
Add sugar to food		
Add salt to food		

**Any known environmental exposures (chemicals, pesticides, heavy metals, etc.)?** \_\_\_\_\_

\_\_\_\_\_

**What hospitalizations or surgeries have you had and when?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**What diagnostic imaging studies have you had?**

Bone density scan

Mammogram

Electrocardiogram

Electroencephalogram

X-rays

CT scan

MRI

Other \_\_\_\_\_

**Immunizations**

Please indicate any of the following immunizations you have had. If unsure, please write a question mark beside the immunization.

Diphtheria

Polio

Measles/Mumps/Rubella (MMR)

Tetanus

Pertussis

Other \_\_\_\_\_

**Infectious Illnesses**

Please indicate whether you have had any of the following conditions:

Diphtheria	Mumps	Polio	Meningitis
German measles	Rheumatic fever	Mononucleosis	Chicken Pox
Measles	Scarlet fever	Sexually transmitted infections	

Other \_\_\_\_\_

**Past and Ongoing Medical Problems**

Please circle. YES= present condition      NEVER =never had the condition      PAST = past condition

Cataracts	YES	NEVER	PAST	Ovarian cysts	YES	NEVER	PAST
Glaucoma	YES	NEVER	PAST	PMS	YES	NEVER	PAST
Arrhythmia	YES	NEVER	PAST	Uterine Fibroids	YES	NEVER	PAST
Atherosclerosis	YES	NEVER	PAST	Fibrocystic Breasts	YES	NEVER	PAST
Heart Attack	YES	NEVER	PAST	BPH	YES	NEVER	PAST
Heart Block	YES	NEVER	PAST	Inguinal Hernia	YES	NEVER	PAST
Heart Failure	YES	NEVER	PAST	Kidney Disease	YES	NEVER	PAST
Heart Murmur	YES	NEVER	PAST	Arthritis	YES	NEVER	PAST
Asthma	YES	NEVER	PAST	Chronic Fatigue Syn	YES	NEVER	PAST
COPD	YES	NEVER	PAST	Fibromyalgia	YES	NEVER	PAST
Pneumonia	YES	NEVER	PAST	Eczema	YES	NEVER	PAST
Tuberculosis	YES	NEVER	PAST	Seizure Disorder	YES	NEVER	PAST
Celiac Disease	YES	NEVER	PAST	Depression	YES	NEVER	PAST
Chrons Disease	YES	NEVER	PAST	Sleep Apnea	YES	NEVER	PAST
Gallbladder Disease	YES	NEVER	PAST	Diabetes	YES	NEVER	PAST
Liver Disease	YES	NEVER	PAST	Hypothyroidism	YES	NEVER	PAST
Irritable Bowel Syn	YES	NEVER	PAST	Hyperthyroidism	YES	NEVER	PAST
Ulcerative Colitis	YES	NEVER	PAST	Anemia	YES	NEVER	PAST
Ulcers	YES	NEVER	PAST	Thrombophlebitis	YES	NEVER	PAST
Cervical Dysplasia	YES	NEVER	PAST	Lupus	YES	NEVER	PAST
Endometriosis	YES	NEVER	PAST	Other _____			
Cancer	YES	NEVER	PAST				

Type    Adrenal    Breast    Colon    Kidney    Leuk/Lymph    Lung    Melanoma    Skin    Pancreatic  
           Pituitary    Prostate    Testicular    Thyroid    Other \_\_\_\_\_

Treatment    Surgical Resection    Radioablation    Chemotherapy    Radiation    Other

## Diet History

Typical Meals (i.e. what you ate yesterday):

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Beverages: \_\_\_\_\_

How much/often do you consume of the following (please circle one for each food)?

Soda or carbonated beverages	NEVER	RARELY	SOMETIMES	FREQUENTLY
White flour products	NEVER	RARELY	SOMETIMES	FREQUENTLY
Fried foods	NEVER	RARELY	SOMETIMES	FREQUENTLY
Raw foods	NEVER	RARELY	SOMETIMES	FREQUENTLY
Refined sugar	NEVER	RARELY	SOMETIMES	FREQUENTLY
Red meat or pork	NEVER	RARELY	SOMETIMES	FREQUENTLY
Tap water	NEVER	RARELY	SOMETIMES	FREQUENTLY
Bottled/filtered water	NEVER	RARELY	SOMETIMES	FREQUENTLY
Fresh vegetables	NEVER	RARELY	SOMETIMES	FREQUENTLY
Fresh fruit	NEVER	RARELY	SOMETIMES	FREQUENTLY
Margarine	NEVER	RARELY	SOMETIMES	FREQUENTLY
Green leafy vegetables	NEVER	RARELY	SOMETIMES	FREQUENTLY
Sweets/deserts	NEVER	RARELY	SOMETIMES	FREQUENTLY
Candy	NEVER	RARELY	SOMETIMES	FREQUENTLY
Margarine	NEVER	RARELY	SOMETIMES	FREQUENTLY
Cook with shortening or oils other than coconut, olive, or butter	NEVER	RARELY	SOMETIMES	FREQUENTLY

Family History	Father	Mother	Brothers			Sisters			Other Relatives		
			1	2	3	1	2	3			
Age (if living)											
Allergies											
Asthma											
Arthritis											
Autoimmune Disorder											
Celiac Disease											
Cancer											
Glaucoma											
Diabetes											
Heart Trouble											
High Blood Pressure											
Stroke											
Epilepsy											
Tuberculosis											
Substance Abuse											
Mental Disorder											
Suicide											
Alzheimer's/ Dementia											
Kidney Trouble											
Thyroid Disorder											
Other Conditions											
Age at Death											
Cause of Death											

For autoimmune, cancer, glaucoma, diabetes, heart trouble, mental disorders, kidney trouble, and thyroid disorder, please indicate specific type if known.  
For Other Relatives please indicate who by using S = son; D = daughter; GF = grandfather; GM = grandmother; U = uncle; A = aunt; C = cousin.  
Please indicate side of family by preceding the above abbreviations with a P = paternal or M = maternal.

### Medications and/or Supplements

Please list, by name, any prescription medications, over-the-counter medications, vitamins, or other supplements you are regularly taking. Include dose (for products containing multiple ingredients give full trade name and brand in lieu of dose) and number of times per day taken, who prescribed it and what is it prescribed or taken for.

Format Examples (follow format exactly, use extra sheet if more space is needed):

Vitamin D3, 2000 IU, 1 softgel 1 time daily with food, self for general health

UltraHigh Multivitamin (Mountain Peak Nutritionals), 2 caps 3x daily, John Doe, ND for general health

Cortisol Manager (Integrative Therapeutics), 2 tabs daily at bedtime, John Doe, ND for insomnia/adrenal stress

Metformin, 1000 mg, 1 tab 2 times daily with meals, Jane Doe, MD for diabetes

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_
- 7) \_\_\_\_\_
- 8) \_\_\_\_\_
- 9) \_\_\_\_\_
- 10) \_\_\_\_\_
- 11) \_\_\_\_\_
- 12) \_\_\_\_\_

(continue on back if necessary)

### Review of Systems

Please read carefully and check all that apply

#### **Constitutional**

- |                                  |                                      |                                      |                                 |
|----------------------------------|--------------------------------------|--------------------------------------|---------------------------------|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Head injury | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Chills |
|                                  | <input type="checkbox"/> Headache    | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Fever  |

Explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Review of Systems (continued)

Please read carefully and check all that apply

### **Eyes**

- |   |                                    |   |   |
|---|------------------------------------|---|---|
| <input type="checkbox"/> Vision changes | <input type="checkbox"/> Tearing   | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Glasses/contacts |
| <input type="checkbox"/> Pain           | <input type="checkbox"/> Dryness   | <input type="checkbox"/> Spots          |   |
| <input type="checkbox"/> Redness        | <input type="checkbox"/> Discharge | <input type="checkbox"/> Double vision  |   |

### **Ears**

- |   |                                  |                                    |
|---|----------------------------------|------------------------------------|
| <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Discharge |
| <input type="checkbox"/> Ringing            | <input type="checkbox"/> Pain    |                                    |

### **Nose/Sinuses**

- |                                     |                                      |  |   |
|-------------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> Congestion | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Discharge  | <input type="checkbox"/> Pain        | <input type="checkbox"/> Obstruction   |   |

### **Mouth/Throat**

- |  |  |                                     |                                      |
|--|--|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Sores             | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Jaw clicks | <input type="checkbox"/> Pain        |
| <input type="checkbox"/> Gingival bleeding | <input type="checkbox"/> Use of dentures | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Sore throat |

### **Neck**

- |                                |                                     |
|--------------------------------|-------------------------------------|
| <input type="checkbox"/> Lumps | <input type="checkbox"/> Tenderness |
| <input type="checkbox"/> Pain  | <input type="checkbox"/> Stiffness  |

### **Breasts**

Date of last mammogram \_\_\_\_\_

- |                                     |   |   |
|-------------------------------------|---|---|
| <input type="checkbox"/> Lumps      | <input type="checkbox"/> Swelling         | <input type="checkbox"/> Do self breast exams |
| <input type="checkbox"/> Tenderness | <input type="checkbox"/> Nipple discharge |   |

### **Cardiovascular**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Chest pain      | <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Discolored hands/feet                           | <input type="checkbox"/> Known heart disease |
| <input type="checkbox"/> Palpitations    | <input type="checkbox"/> Leg Pain       | <input type="checkbox"/> High blood pressure                             |  |
| <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> High cholesterol                                |  |
| <input type="checkbox"/> Fainting        | <input type="checkbox"/> Blood clots    | <input type="checkbox"/> Easily becoming short of breath during activity |  |

### **Respiratory**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Cough                   | <input type="checkbox"/> Wheezing             | <input type="checkbox"/> Shortness of breath                |
| <input type="checkbox"/> Sputum                  | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Shortness of breath lying down     |
| <input type="checkbox"/> Spitting/coughing blood | <input type="checkbox"/> Pain with breathing  | <input type="checkbox"/> Shortness of breath that wakes you |

### Review of Systems (continued)

Please read carefully and check all that apply

#### **Gastrointestinal**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Belching           | <input type="checkbox"/> Easy satiety          | <input type="checkbox"/> Mucus in stools           |
| <input type="checkbox"/> Heartburn/ Reflux  | <input type="checkbox"/> Flatulence         | <input type="checkbox"/> Food sits in stomach  | <input type="checkbox"/> Undigested food in stools |
| <input type="checkbox"/> Nausea             | <input type="checkbox"/> Bloating           | <input type="checkbox"/> Anal itching          | <input type="checkbox"/> Shiny/greasy stools       |
| <input type="checkbox"/> Vomiting           | <input type="checkbox"/> Indigestion        | <input type="checkbox"/> Vomiting Blood        | <input type="checkbox"/> Poorly formed stools      |
| <input type="checkbox"/> Constipation       | <input type="checkbox"/> Abdominal pain     | <input type="checkbox"/> Blood in or on stools | <input type="checkbox"/> Abnormal stool color      |
| <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Black tarry stools    |  |

How many bowel movements per day? \_\_\_\_\_ What color are they? \_\_\_\_\_

#### **Urinary**

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Pain/ discomfort   | <input type="checkbox"/> Hesitancy       | <input type="checkbox"/> Post-void dribbling  | <input type="checkbox"/> Blood in urine      |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Decreased force | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Discharges          |
| <input type="checkbox"/> Urgency            | <input type="checkbox"/> Split stream    | <input type="checkbox"/> Frequency at night   | <input type="checkbox"/> Frequent infections |

#### **Reproductive (Male)**

- |  |  |  |                                       |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Testicular mass       | <input type="checkbox"/> Diminished libido     | <input type="checkbox"/> Other sexual difficulties | <input type="checkbox"/> Heterosexual |
| <input type="checkbox"/> Genital pain/ itching | <input type="checkbox"/> Erectile dysfunction  | <input type="checkbox"/> Do self testicle exams    | <input type="checkbox"/> Homosexual   |
| <input type="checkbox"/> Genital sores         | <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Sexually active           | <input type="checkbox"/> Bisexual     |
| <input type="checkbox"/> Genital discharge     | <input type="checkbox"/> Problems with orgasm  | <input type="checkbox"/> Multiple sex partners     |                                       |

Use birth control (if yes, what type) \_\_\_\_\_

#### **Reproductive (Female)**

Age of first menses \_\_\_\_\_ Age of last menses (if menopausal) \_\_\_\_\_

Length of cycle (period-to-period) \_\_\_\_\_ Duration of menses (# days of bleeding) \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_ Date of last annual exam/ PAP \_\_\_\_\_/\_\_\_\_\_

- |   |   |  |                                       |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Painful menses           | <input type="checkbox"/> Pelvic pain                | <input type="checkbox"/> Genital sore              | <input type="checkbox"/> Heterosexual |
| <input type="checkbox"/> Irregular cycle          | <input type="checkbox"/> Fertility issues           | <input type="checkbox"/> Vaginal dryness           | <input type="checkbox"/> Homosexual   |
| <input type="checkbox"/> Heavy flow               | <input type="checkbox"/> Frequent infections        | <input type="checkbox"/> Problems with orgasm      | <input type="checkbox"/> Bisexual     |
| <input type="checkbox"/> Clotting                 | <input type="checkbox"/> Diminished libido          | <input type="checkbox"/> Physical arousal problems |                                       |
| <input type="checkbox"/> Vaginal discharge        | <input type="checkbox"/> Bleeding after intercourse | <input type="checkbox"/> Other sexual difficulties |                                       |
| <input type="checkbox"/> Bleeding between periods | <input type="checkbox"/> Pain with intercourse      | <input type="checkbox"/> Sexually active           |                                       |
| <input type="checkbox"/> Premenstrual cramping    | <input type="checkbox"/> Genital pain/ itching      | <input type="checkbox"/> Multiple sex partners     |                                       |

Use birth control (if yes, what type?) \_\_\_\_\_

Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_

Number of miscarriages \_\_\_\_\_ Number of abortions \_\_\_\_\_

## Review of Systems (continued)

Please read carefully and check all that apply

### **Musculoskeletal**

- |                                     |                                      |                                   |  |
|-------------------------------------|--------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Swelling | <input type="checkbox"/> Muscle spasms           |
| <input type="checkbox"/> Stiffness  | <input type="checkbox"/> Back pain   | <input type="checkbox"/> Redness  | <input type="checkbox"/> Limited range of motion |

### **Skin**

- |                                  |                                   |  |
|----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Rashes  | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Color changes |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Lumps    |  |

### **Neurological**

- |  |                                     |   |   |
|--|-------------------------------------|---|---|
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Numbness   | <input type="checkbox"/> Vertigo              | <input type="checkbox"/> Difficulty walking |
| <input type="checkbox"/> Seizures              | <input type="checkbox"/> Tingling   | <input type="checkbox"/> Memory loss          |   |
| <input type="checkbox"/> Paralysis             | <input type="checkbox"/> Tremors    | <input type="checkbox"/> Disorientation       |   |
| <input type="checkbox"/> Muscle weakness       | <input type="checkbox"/> Nerve pain | <input type="checkbox"/> Changes in mentation |   |

### **Emotional**

- |                                      |                                      |   |
|--------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Tension     | <input type="checkbox"/> Changes in thought content         |
| <input type="checkbox"/> Anxiety     | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Trouble concentrating              |
| <input type="checkbox"/> Stress      | <input type="checkbox"/> Sadness     | <input type="checkbox"/> Thoughts of harming self or others |

Sleep:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> 6-8 hours sleep nightly | Bedtime (typical) _____PM                                  | Waketime (typical) _____AM                     |   |
| <input type="checkbox"/> Trouble falling asleep  | <input type="checkbox"/> Snoring                           | <input type="checkbox"/> Restless Leg Syndrome | <input type="checkbox"/> Other sleep problems |
| <input type="checkbox"/> Trouble staying asleep  | <input type="checkbox"/> Wake feeling rested and refreshed |  |   |

### **Endocrine**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Heat intolerance | <input type="checkbox"/> Excessive thirst       | <input type="checkbox"/> Brain fog     | <input type="checkbox"/> Hair loss                |
| <input type="checkbox"/> Cold intolerance | <input type="checkbox"/> Excessive hunger       | <input type="checkbox"/> Hypoglycemia  | <input type="checkbox"/> Dry hair                 |
| <input type="checkbox"/> Cold hands       | <input type="checkbox"/> Excessive urination    | <input type="checkbox"/> Brittle nails | <input type="checkbox"/> Hot flushes/night sweats |
| <input type="checkbox"/> Cold feet        | <input type="checkbox"/> Excessive perspiration |  | <input type="checkbox"/> Seasonal depression      |

### **Blood/Lymph**

- |  |   |
|--|---|
| <input type="checkbox"/> Easy bruising           | <input type="checkbox"/> Slow wound healing |
| <input type="checkbox"/> Easy/prolonged bleeding | <input type="checkbox"/> Swollen glands     |

### **Allergic/Immunologic**

- Allergies:  molds/  pollens/  grasses/  dust/  foods/  medications/  other \_\_\_\_\_
- Frequent colds or flus       Chronic infections       Adverse vaccine reactions

Is there anything else you would like us know in order to serve you better? \_\_\_\_\_

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# Salem Natural Medicine

PLEASE READ CAREFULLY BEFORE INITIALING OR SIGNING.

**Consent for Treatment:**

Naturopathic medicine therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to soreness, inflammation, soft tissue injury or bruising, dizziness, burns, temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain to your satisfaction, please ask for more information. I understand that my care is directed by my physician(s) at Salem Natural Medicine and I consent to services rendered and provided.

I have fully read and understand the above agreement and authorization and I also understand that there is no guarantee for a specific cure or result.

\_\_\_\_\_  
Patient (18 years or older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent, Guardian, Responsible Party

\_\_\_\_\_  
Date



### HIPAA Consent Form

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

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information 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 then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

\_\_\_\_\_  
Patient Name:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Patient  
if signed by someone other than patient

\_\_\_\_\_  
Date



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

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, \_\_\_\_\_, hereby acknowledge that Salem Natural Medicine has provided me with a copy of its **Notice of Privacy Practices** that describes how medical information about me may be used and disclosed, and how I can access this information.

I understand that if I have questions or complaints I may contact:

**Timothy Murbach, ND • 503-383-1256**

I also understand that I am entitled to receive updates upon request if Salem Natural Medicine amends or changes its **Notice of Privacy Practices** in a material way.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Patient  
if signed by someone other than patient

\_\_\_\_\_  
Date

**THIS SECTION IS TO BE COMPLETED BY SALEM NATURAL MEDICINE  
IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT**

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named client, but was unable to because:

Client declined to sign this Written Acknowledgment.

Other (specify): \_\_\_\_\_

\_\_\_\_\_  
Name and title of employee

\_\_\_\_\_  
Date



**Statement of Financial Responsibility:** I understand and agree to the following:

- Payment for services rendered are my responsibility as the patient or patient’s responsible party.
- I am responsible for paying for all services, including lab tests, rendered at the time of service.
- If I am receiving a discount of any sort, I am responsible for providing accurate and thorough documentation supporting it and I am responsible for paying in full at the time of service.
- Credit card payments are subject to an additional processing fee, not to exceed 5% of total payment.
- There is a \$75 returned check fee.
- Any items from the medicinary must be paid in full upon receipt. There can be no refunds for products which have been opened, special order items, or for custom formulations.
- **Cancelled and missed appointment charges:**

Due to the significant time set aside in the doctor's schedule for patient appointments, a 48 hour business day cancellation is required for all patient appointments. Weekend days are not included in this. Salem Natural Medicine does not double book appointment times, so when an appointment is made that time slot has been reserved for you. If you fail to keep this appointment, it prevents others from being treated.

New Patients: All new patient appointments that are canceled without a 48 hour business- day notice will be charged a \$200.00 cancellation fee. There are no exceptions.

Established Patients: Any missed appointments, or cancellations with less than a 48 hour business-day notice will incur a charge of \$100. There are no exceptions.

Reasonable emergencies will be forgiven at our discretion.

- Phone Call/ email policy: Patients are welcome to call if you have questions after your office visit. Often, clarifying issues and answering basic questions can greatly enhance the success of your health care. Due to time constraints, however, phone calls or emails requiring longer than 5 minutes regarding existing treatments, or any new conditions will be billed as a phone or email consultation.

**Insurance billing:** If I am billing insurance for services rendered, I understand and agree to the following:

- I authorize Salem Natural Medicine to release pertinent medical records related to billing directly to my insurance carrier. This release applies to support of the insurance billing process only.
- I am responsible for any and all charges that my insurance company will not cover.
- I must pay for all services in full until coverage has been verified by my insurance company. Verification typically occurs **before** the 1<sup>st</sup> visit. Salem Natural Medicine will provide me with codes necessary for self-billing the insurance company, should verification be delayed or not possible.

By signing below, I \_\_\_\_\_ certify that I fully understand the above policies.

\_\_\_\_\_  
Signature of patient or patient’s responsible party

\_\_\_\_\_  
Date