CONFIDENTIAL PERSONAL INFORMATION

Full Legal Name: ______________________________/__________________________/_________
(Last Name) (First Name) (Middle Initial)

Preferred Name: ____________________ Age: _________ Date of Birth: ______________________

Address:_______________________________________/___________/_______/_____________
(street#/PO Box) (city) (state) (Zip code)

Telephone # _(____)____________/_(____)_________________/_(____)______________________
(home) (work) (cell phone or other)

E-mail address: _______________________________________ Gender: female _____ male _____

Are you (check one): Single ____ Married ____ Other ____ Partner's Name: __________________

Occupation: _________________________________(circle) Full time/ Part time /Student/ Retired

Employer / School: ____

Address: ______________________/_________________/_____________/________________
(Street / PO Box) (City) (State) (Zip code)

How did you hear about Dr. Hodsdon? ____

Emergency Contact ____
(Name) (Relationship)

_(_____)____(_____)_________________________
(Day Phone) (Evening Phone)

What is the **best way** to communicate with you between office visits? (E-mail, Home, Work, Cell Phone).
Is there any place you do **NOT** want me to leave a message? ___________________

Please be aware that e-mail is not a secure communication and that discussion of your medical care will become part of your medical record.

May Dr. Hodsdon discuss your private medical information with you via e-mail? ☐ Yes ☐ No

Insurance Information – Please provide copy of front and back of Insurance card.

☐ **Group Insurance:** Insurance Co: ____

Insured Full Legal Name: _______________________________________ Date of Birth: ___/___/___

Insured's Address:______________________/__________/_____/_________/(____)____________
(street / PO Box) (City) (State) (Zip Code) (Phone Number)

☐ **MVA:** Date of MVA: __________ State MVA occurred: ______ Claim number: ______________

Insurance Co: ___________ Claim submitted ☐ Y ☐N Adjuster: ________ Phone: (____)________

Attorney's Name: ________________ Phone: (__)____________ PIP Coverage: ______________

Do you have any secondary or additional Insurance plans? ☐ Yes ☐ No Name: ____________

By signing below, I verify that the above information is correct and true to the best of my knowledge.

Signature of Patient ____ Today's Date___________

Wendy Hodsdon, ND
Portland Alternative Medicine, LLC
4425 SW Corbett Ave Portland, Oregon 97239
Phone (503) 227-8700 Fax (503) 227-8702

www.PortlandAlternativeMedicine.com
DrWendy@PortlandAlternativeMedicine.com

Name: ____

Massage and Cranial Therapy - CONFIDENTIAL HEALTH HISTORY

What brings you in today? What are your intentions / expectations?

____

____

Please indicate other health care services you are currently using and for what purpose:

____

____

Please note below any injuries, surgeries, accidents, falls, broken bones, motor vehicle accidents or other traumas you have experienced: (Even if they were minor or happened a long time ago.)

Traumatic Event	Happened When	Injured What

Health Conditions

Check any of the following you have or have had in the past 6 months.

___ Heart Condition	___ Cancer	___ Fatigue
___ Varicose Veins	___ Depression	___ Sleep Disorders
___ Blood Clots	___ Pregnancy	___ Numbness / Tingling
___ Bruise easily	___ Severe Menstrual cramping	___ Chronic Pain
___ High Blood Pressure	___ Excessive / lack of Menstruation	___ Rashes
___ Low Blood Pressure	___ Intense PMS	___ Scars
___ Diabetes	___ Endometriosis	___ Open Cuts or Sores
___ Breathing Difficulties	___Communicable Disease	___ Skin Disease
___ Sinusitis	___ Herpes	___ Melanoma
___ Allergies To what: _______	___ Seizures	
_________________________	___ Arthritis	

Anything else you would like to communicate about your health history:__________________________

____

____

Name: ____

PORTLAND ALTERNATIVE MEDICINE FINANCIAL POLICIES

1) **Unless prior arrangement is made, full payment is due at the time of service.**

   Your payment options are: cash, check, or credit/debit cards.
   We accept Visa, Master Card, Discover, or American Express.

2) Insurance Billing

   - If you would like us to bill your insurance, we will contact your insurer(s) and bill them based upon the **non-guaranteed** information they provide to us.
   - You are responsible for all co-payments, deductibles and other adjustments made by your insurer(s).
   - **If we are unable to obtain a verification of benefits from your insurer for any reason, we will require full payment at the date and time of service.**
   - Insurance companies may reimburse differently than the information they initially provide to us.
   - **You are responsible for and will be billed for any resulting unpaid balance.**

3) Discounts

   We offer the following discounts. Only one discount may be applied to a bill.

   - "Time Of Service Discount"

   If you are paying in full for a treatment at the time of service, you will receive a 20% discount on Naturopathic, and Massage services. This discount does not apply to co-payments, products, individual payment plans, or services other than those listed above.

   - "Time Of Service Student Discount"

   Students, currently enrolled in accredited natural health academic programs, will receive a 30% discount on all services and 20% discount on all products if they pay in full at the time of service.

4) Missed Appointments/Late Cancellations

   All appointment cancellations must occur within 24 hours of the appointment. If it is less than 24 hours, **you will be charged $25 for the missed appointment.**

5) Past Due Accounts

   Accounts greater than 30 days past due will be charge a $10 administrative fee.
   Accounts greater than 90 days overdue will be sent to a collections agency.

These policies are subject to change without notice.
We also post our financial policy at www.PortlandAlternativeMedicine.com/financialpolicies

I have read, understood and agree to the policies described above:

Print Name:______________________ Sign:______________________ Date:__________

Name: ____

INFORMED CONSENT

The purpose of this form is to present risks and benefits of the therapies I offer. **Please initial the sections that apply to you. This must be signed before treatment is rendered.** Ask me of you have any questions or concerns at any time.

NATUROPATHIC MEDICINE Initials:______ Date:____________________
Naturopathy combines safe and effective traditional therapies with the most current advances in modern medicine by attempting to find the underlying cause rather than focusing on symptomatic treatment. The doctors in our clinic treat a variety of conditions including women's health, stress, pain, organ dysfunction, infections, and much more. There is risk of pharmaceutical/supplement interaction, so inform your ND of current medications. Your ND may suggest hydrotherapy, which encourages circulation, enhanced immune function and relaxation. Side effects are minimal, but may include dizziness, fatigues, detoxification reactions and irritated skin.

MASSAGE, TRIGGER POINT THERAPY, EXERCISES, STRETCHING Initials:______ Date:____________________
The goal of massage/soft tissue therapy is to decrease the tension and tenderness, while increasing blood/lymph flow. Your problem may be caused by poor mechanics/repetitive stress, in which case, exercises or stretches may be indicated. Deep tissue work, overstretching and over-exercise may cause discomfort or injury. Massage may cause initial soreness, bruising or lightheadedness, but usually pain relief, increased motion, and relaxation are experienced.

SUPPLEMENTS, HERBALS, HOMEOPATHICS Initials:______ Date:____________________
These are products that can aid in healing by nutritional, energetic, and mechanical support; They can be effective for many conditions. Be sure to inform your practitioner about all medications you currently take to minimize drug/supplement interactions. Some side effects may be gas, bloating, and less commonly allergic reaction. If biomechanical support is needed, back braces, cervical pillows, cervical traction, or orthotics may be suggested for your particular case.

IMAGING, REFERRALS Initials:______ Date:____________________
Further lab work (X-rays, MRI, blood work, urine analysis, etc.) may be necessary. When co-management or referral is indicated, a prompt referral to another specialist for evaluation or alternative therapy will be suggested. The following are examples: medical management (referral to a specialist such as neurologist, ENT, allergist, ect), physical therapy, vestibular testing, psychological evaluation, injection therapy, surgery, naturopathic, chiropractic, acupuncture, massage, etc.

There are many alternatives to the therapies I offer. I recommend consulting with your Primary Care Physician if you have any concerns about my recommendations.

Please inform Dr. Hodsdon of any changes in symptoms, medications, diagnoses by other doctors, and if there is a chance of pregnancy at any time during your care.

- I have had the opportunity to read this form and my questions are answered to my satisfaction. I hereby consent to the treatments initialed above.

Patient Name (Please Print) ____

____________________________________ ____________________
Signature (Patient or Guardian if a minor) Date

Name: ____

Notice of Privacy Practices

This Notice explains how our office may use and disclose your protected health information and your rights regarding how we protect your health information. "Protected health information," including demographics, can be reasonably used to identify you, relates to your past, present or future physical or mental health condition, the provision of care to you, or the payment for that care. We reserve the right to change the terms of this Notice and our privacy policy at any time. Any changes will apply to all protected health information that we maintain effective the date of a new Notice. New Notices will be posted at Portland Alternative Medicine clinic and you may obtain one at any time. This Notice goes into effect February 3, 2008.

Uses and Disclosures

We may use and disclose your health information for different reasons.

- **Treatment:** To assist in your diagnosis and treatment.
- **Payment:** In order to bill and collect payment for services provided. For example, to claims processing companies, others that participate in the claims payment process and your health insurance plan to get reimbursed for services.
- **Health Care Operations:** For activities necessary such as quality management, utilization review, anti-fraud and claims payment, provider credentialing activities, and as required by industry or government regulators such as state licensing boards, insurance regulatory agencies, and the sponsor of your health plan.

Our office may not use or disclose any more of your protected health information than is necessary to accomplish the purpose of the use or disclosure, except for treatment purposes.

We must disclose, when required by law, for the following examples:

- **Avoid threat to health or safety.** To law enforcement personnel or persons able to prevent or lessen a serious threat to public safety.
- **Coroners, Funeral Directors, Organ Donation.** To said professionals such that they can carry out their duties.
- **Health oversight activities.** To assist the government agencies, such as when it conducts an investigation or inspection of a health care organization.
- **Health-related benefits or services.** For appointment reminders or to give you information about treatment alternatives or services that may be of interest to you.
- **Law Enforcement, judicial and administrative proceedings.** In response to a subpoena, discovery request, in response to a warrant, to identify or locate a suspect, to provide information about a victim of a crime, or other lawful process.
- **National security and intelligence.** As required by military officials for security and military purposes.
- **Public health activities.** To public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Research.** For medical research – Such circumstances include taking steps to protect your privacy.
- **Victims of abuse, neglect or domestic violence.** To government agencies and law enforcement personnel as required by law.
- **Workers' compensation.** In compliance with workers' compensation laws.

Authorization

Any uses or disclosures other than those described above will be made **only** with your prior written authorization, unless otherwise permitted or required by law. In the event that you authorize us to use your protected health information for other uses, you have the right to revoke any authorization by delivering a written revocation statement, except to the extent that we have already disclosed the information or are allowed by law to use the information to contest a claim or coverage.

Name: ____

Patient Rights

Right to request restrictions on uses and disclosures: To request a restriction, please write a request to Portland Alternative Medicine. Upon receiving your request, we will put the limits and terms in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required to make.

Right to receive confidential communications: This includes the right to direct where communications are sent. For example, you may request that information be sent to our work address rather than your home address or via Email than by regular mail. To verify or modify where or how you would like communication sent, contact Portland Alternative Medicine Clinic. Unless requested otherwise, we will direct mailings and telephone messages to the address/telephone number we have on record.

Right to inspect and copy. Includes the rights to see and get copies of your information that we maintain. Submit your request in writing to Portland Alternative Medicine Clinic and we will respond to you within 30 days of receipt of your written request. We will charge you a reasonable copying fee for each page and mailing costs but will inform you of that fee in advance.

Right to amend: If you believe there is a mistake or missing information, you have the right to request that we correct or add to your file. You must provide the request in writing to Portland Alternative Medicine Clinic. We will respond within 60 days of receipt of your written request. We may deny your request in writing if your information is 1) correct and complete, 2) not created by us, 3) not allowed to be disclosed, or 4) not part of our records. Upon approval, we will make the changes, inform you when the changes are complete, and inform others that need to know about the change in a timely manner. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. You also have the right to request that copies of your initial request and our denial be attached to all future disclosures of your information.

Right to receive an accounting of disclosures. This will not include uses or disclosures made for treatment, payment or health care operations, disclosures made directly to you, those you have already authorized, those made for national security reasons or to law enforcement that has lawful custody over you. We will respond within 60 days of receiving written request. Please include the time period for which you want the accounting (can be no longer than 6 years and may not include dates before April 14, 2003). The accounting will include the date of the disclosure, to whom information was sent, a brief description of the information disclosed, and a brief statement of the purpose for the disclosure. We will provide the first accounting at no charge. For additional accountings, we may charge you a fee but will inform you of that fee in advance.

Right to get a paper copy of this Notice. At any time even if you previously agreed to receive an electronic copy.

Right to file a complaint. If you believe your health information has been improperly used or disclosed, or that your privacy rights have been violated, you may file a privacy complaint with us. Contact Portland Alternative Medicine Clinic to file a complaint. You also have the right to file a complaint with the Secretary of the US Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint with us or the DHHS.

I acknowledge having carefully read this copy of the Notice of Privacy Practices.

Patient Name (Please print)____

Patient/Guardian Signature____ Date__________________

Relationship to Patient (if other than self):____

Note: if this acknowledgement is being signed by a legal representative, you must provide a copy of the power of attorney or other relevant document(s) designating you as the legal representative.