POWELL VALLEY WELLNESS

Address: 4253 SE 182nd Ave. Gresham, OR, 97030
Phone: 503-661-5090

Date:_____

MRN:_____

DOB:_____

New Naturopathic Medicine Patient Registration

Demographics

(Please write clearly)

Patient Full Name: _____ DOB: _____

(Last Name) (First Name) (Middle Name)

Other Names Used: _____

What is your preferred first name? (Nickname, Chosen name, etc.) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell phone: _____ Email Address: _____

Preferred Contact Phone Number: □ Cell □ Home □ Work

How may we contact you? □ Text □ Email □ Phone □ Postal Mail

May we leave confidential voicemail messages on your phone? □ Yes □ No

SSN: _____ (For your identity privacy and is used solely for that purpose)

The following information you provide us helps to serve you and members of the community.

What was your assigned sex at birth?	□ Male	□ Female	Other(specify)_____
What gender do you identify as?	□ Male	□ Female	Other(specify)_____
What pronoun do you use?	□ He/Him/His	□ She/Her/Hers	Other(specify)_____

Interpreter needed? □ Yes □ No Primary Language: _____

Homeless Status? □ Not Homeless □ Homeless □ At Risk □ Transitional Housing □ Living in Shelter

Seasonal or Migrant Worker? □ Seasonal □ Migrant □ Neither

Ethnic Group (Select One): □ Hispanic □ Non-Hispanic □ Other _____

Race (Select all that apply): □ Asian □ Black □ White □ Alaskan Native □ Pacific Islander
□ American Indian □ Other _____

Are you a US Veteran? □ Yes □ No

Occupation: _____ Hours per Week: _____ Employer: _____

Employment Status (Check all that apply): □ Full Time □ Part Time □ Not Employed □ Retired □ Seasonal
□ Self-Employed □ Student (Full Time) □ Student (Part Time)

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New Naturopathic Medicine Patient Registration *(continued...)*

PRIMARY CARE PROVIDER: ***(Please select one of the following):***

☐ I wish to establish Primary Care with Dr. Petshow.

☐ I see Dr. Petshow for ancillary/adjunctive care only.

My Primary Care Physician (PCP) is: _____

At (Clinic Name): _____

☐ I do not have a Primary Care Physician and do not wish to establish Primary Care at this time.

EMERGENCY CONTACT: ***(The person we will call in the event of an emergency)***

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Legal Guardian? □ Yes □ No

GUARANTOR: ***(The person who is financially responsible for the account):***

Name: _____ Relationship to the patient: _____

Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Gender: □ M □ F □ Other DOB: _____

Guarantor Primary Language: _____ Phone: _____

INSURANCE: ***(Please provide your insurance information below)***

Please be prepared to present your insurance card at check-in for each visit.

Insurance Company: _____

Claims Address: _____

Subscriber Name (if other than patient): _____ DOB:_____

Member ID#: _____ Group #: _____ Subscriber ID #: _____

Second Coverage Insurance Company (*optional*): _____

Claims Address: _____

Subscriber Name (if other than patient): _____DOB:_____

Member ID#: _____ Group #: _____ Subscriber ID #: _____

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OPTIONAL: ***I authorize the following individual(s) to arrange appointments at Powell Valley Wellness on my behalf:***

Name: _____
DOB: _____
Relationship to Patient: _____

Name: _____
DOB: _____
Relationship to Patient: _____

AUTHORIZATION: ***I certify the above information is true and correct to the best of my knowledge.***

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

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Naturopathic Medicine Consent to Establish Care

Informed consent is a process, not a form, and involves an ongoing, interactive dialog between you and your provider. The process of informed consent occurs when communication between you and your provider results in your authorization or agreement to undergo a specific medical intervention.

I do hereby give my consent to services rendered and provided to me (or the patient named below, for whom I am legally responsible) as a patient of Powell Valley Wellness. I understand that patient care is directed by licensed health care providers who are employees of Powell Valley Wellness. I consent to services rendered to me under the instructions of these professionals, as well as volunteer staff physicians who may be associated for the purpose of consulting.

I understand I have the right to ask questions and discuss to my satisfaction with my healthcare provider(s):

- My suspected diagnosis(s) or condition(s)
- The nature, purpose, goals, and potential benefits of the proposed care
- The inherent risks, complications, potential hazards, and/or side effects of treatment or procedure
- The probability or likelihood of success
- Reasonable available alternatives to the proposed treatment procedure
- Potential consequences if treatment or advice is not followed and/or nothing is done

I understand that evaluation and treatment may include, but is not limited to:

- **Common diagnostic procedures** (including but not limited to physical examination, laboratory testing of blood and other bodily fluids, ultrasound, and referrals for external diagnostic procedures).
- **Soft tissue treatment** (including but not limited to massage, neuro-muscular technique, and muscle energy technique) and naturopathic osseous manipulation of the spine and extremities (see Physical Medicine treatment section below for detail).
- **Dietary and therapeutic nutrition** recommendations and counseling (including but not limited to the use of foods, individualized diet plans, nutritional supplements, and parenteral (intravenous or intramuscular) vitamin injections (see separate Parental Injection consent below).
- **Natural substance prescriptions** (including but not limited to plant/herbal, mineral or animal-based substances in full strength or highly diluted/homeopathic). Substances may be given in the forms of teas, pills, creams, powders, tinctures (which may contain alcohol), suppositories, topical creams, pastes, plasters, washes, or other forms.
- **Counseling** (including but not limited to mindfulness techniques, behavioral change, stress management techniques, and tobacco/substance use cessation).
- **Over-the-counter and prescription medications** (including only those medications listed on the Oregon Board of Naturopathic Medicine formulary).

Continued on next page...

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Naturopathic Medicine Consent to Establish Care

Continued...

- **Hydrotherapy procedures** (including but not limited to alternating hot and cold applications, baths, sauna, ice, towels and/or sheets, electrical stimulation, ultrasound) and other therapies. Possible risks and complications associated with these procedures may include:
    - Mild skin burns/irritation, overheating, skin rash, dizziness, or temporary decrease in blood pressure
- **Physical medicine** treatments including examination, diagnostic procedures, manipulation and/or mobilization of the neck, spine, and extremities involving movement of the joints and soft tissues, and soft tissue therapies (specifically: manual soft tissue therapies, instrument-assisted soft tissue mobilization (IASTM), percussion/vibration therapy and therapeutic tape procedure). Physical therapy, including exercise, electrical stimulation, hot/cold therapies, ultrasound, TENS units, low-level laser therapy, traction, and other therapeutic modalities recommended for my condition may also be used. Possible risks and complications associated with these procedures may include:
    - Soreness, muscle spasm, temporary increase in blood pressure, sprains and strains, dizziness, fractures or joint injury, mild to moderate bruising, physical therapy burns *(rare)*, or stroke *(has been rarely reported to occur specifically from neck manipulation)*.
- **Parenteral Injection (Intravenous [IV] and Intramuscular) Therapy** treatments including drips and pushes. This treatment involves inserting a needle and injecting a standardized formula into veins or muscles. Possible risks and complications associated with these procedures may include:
    - Pain, bruising, or infection at the injection site.
    - Inflammation of vein used for infusion *(phlebitis)*.
    - Severe allergic reaction or anaphylaxis resulting in cardiac arrest, possibly death.
    - **Alternatives to IV therapy include:** oral supplementation or lifestyle/dietary changes.

I understand that some medicines, supplements and procedures may be inappropriate during pregnancy. If I suspect I am pregnant, I will immediately inform my provider so that my treatment plan may be re-evaluated.

*Please note: There are additional consent forms for Parenteral injections, minor surgery, hormone treatments and other special procedures or services.

I have fully read and understand the above and hereby consent to services.

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

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HIPAA Notice of Privacy Practices and Consent

I hereby consent to the use and disclosure of my Protected Health Information by Powell Valley Wellness for the purposes of **treatment**, **payment and healthcare operations**, or as otherwise required by law.

- I have the right to request restrictions to the usage and disclosure of my Protected Health Information.
- I have the right to request an alternative to the standard method of communication of my Protected Health Information.
- I have the right to revoke this consent, in writing, at any time. Revocations will be honored as of the date they are received by the Powell Valley Wellness.
- I understand that while Powell Valley Wellness may honor these requests, they are not required by law to do so.
- I am aware that Powell Valley Wellness reserves the right to change the terms of their Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all Protected Health Information that they maintain.

In the event of amendments, Powell Valley Wellness will make available a revised Notice of Privacy Practice for my review.

I have fully read and understand the above agreements and authorizations.

_____

Patient Signature (18 years or older) Date

_____

Parent, Guardian, Responsible Party (printed name) Date

_____

Parent, Guardian, Responsible Party Signature Date