WHITAKER WELLNESS, LLC POWELL VALLEY WELLNESS

New Naturopathic Medicine Patient Registration

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

Gender: ☐Male ☐Female Other(specify) _______________________

Employer:__________________________ Occupation:____________________

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

☐I wish to establish ancillary/adjunctive care only.

My Primary Care Physician (PCP) is:______________________________

At (Clinic Name):____

☐I wish to establish Primary Care at Powell Valley Wellness.

PHARMACY: ____

(Name) (Address) (Phone)

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

Naturopathic Medicine Consent to Treat

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 Parenteral Injection consent).
- 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).

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.

______________________________________ ____________________

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

Consent for Telemedicine Services

Introduction

Telemedicine is the delivery of healthcare services when the healthcare provider and patient are not in the same physical location through the use of technology. Providers may include primary care practitioners, specialists, and/or subspecialists. Electronically-transmitted information may be used for diagnosis, therapy, follow-up and/or patient education, and may include any of the following:

- Patient medical records.
- Medical images.
- Interactive audio, video, and/or data communications.
- Output data from medical devices and sound and video files.

The interactive electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Potential Benefits:

1. Improved access to medical care by enabling a patient to remain in his/her physicians's office (or at a remote site) while the physician obtains test results and consults with healthcare practitioners at distant/other sites.
2. Obtaining the expertise of a distant specialist.

Potential Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

1. Information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s).
2. The consulting physician(s) are not able to provide medical treatment to the patient through the use of telemedicine equipment nor provide for or arrange for any emergency care that I may require.
3. Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
4. Security protocols could fail, causing a breach of privacy of personal medical information.
5. A lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other medical judgment errors.

By signing this form, I understand and agree to the following:

1. The laws that protect the privacy and confidentiality of medical information also apply to telemedicine. No information obtained during a telemedicine encounter which identifies me will be disclosed to researchers or other entities without my consent.
2. I have the right to withhold or withdraw my consent to the use of telemedicine during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment, nor will it subject me to the risk of loss or withdrawal of any health benefits to which I am otherwise entitled.
3. I have the right to inspect all information obtained and recorded during the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. A variety of alternative methods of medical care may be available to me, and I may choose one or more of these at any time.
5. Telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out-of-state.
6. I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured. My condition may not be cured or improved, and in some cases, may get worse.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby consent to and authorize my provider to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient: ____________________________________ Date: ________________

(or person authorized to sign for Patient)

If authorized signer, relationship to patient: ____

WHITAKER WELLNESS, LLC POWELL VALLEY WELLNESS

Patient Authorization Form

I have had the **Notice of Privacy Practice** made available to me and have had the opportunity to review its contents prior to signing this authorization.

I authorize the use of my medical information according to the **Notice of Privacy Practice**.

I authorize the release of any medical information necessary to process my claim.

I authorize the following individual(s) (family, spouse, friends) access to information about my medical records and appointments at **Whitaker Wellness / Powell Valley Wellness**:

Name(s): ____

I authorize **Whitaker Wellness / Powell Valley Wellness** to send text message reminders about my appointments and to leave a message whenever they need additional information from me.

- ☐ Check box if you want to **OPT OUT** of voicemails.
- ☐ Check box if you want to **OPT OUT** of text message reminders.
- ☐ Check box if you want to **OPT OUT** of Email reminders.

I authorize payment of medical benefits to **Whitaker Wellness / Powell Valley Wellness**

I authorize the release of information to any other entity for which I have signed a release.

I authorize **Whitaker Wellness / Powell Valley Wellness** to release information to any entity that I personally instruct them to release information to.

We, at **Whitaker Wellness / Powell Valley Wellness**, will gladly bill your insurance company. However, the full responsibility for payment of all professional services belongs to you, the patient.

If you do not have insurance or choose not to use your insurance, we do offer a Time Of Service Discount (TOSD) here. The TOSD will give you discount on your treatments here. You can use the TOSD for any service offered here. Pricing is dependent on the services performed. Please ask the front desk for specific pricing. **In order to qualify for the TOSD you have pay for your services the day of visit. If you do not pay the same day you were seen then you do not qualify for the TOSD and must pay full pricing.**

_____________________________ _________________________

Patient Name Date

____ _______________________________

Patient Signature (Parent Signature if minor) Parent Name (If Minor)

WHITAKER WELLNESS, LLC POWELL VALLEY WELLNESS

Cancellation Policy/No Show Policy for Doctor Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "Full" appointment book.

If any appointment is not canceled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

________________________________ __________________
Patient name Date

____
Signature Patient/Guardian

WHITAKER WELLNESS, LLC POWELL VALLEY WELLNESS

What is the reason(s) for your visit to our clinic today?

Primary concern:_______________________________

Additional concern(s)*:_____________________________

*Please note that we may not be able to address all of your concerns in a single visit and follow up visits may be needed.

Allergies: Please list all (medication, food, environmental)

____
____
____

Vaccination History:

☐Polio ☐DtaP/TDaP ☐MMR ☐HPV ☐Hepatitis A ☐Pertussis

☐Varicella ☐Tuberculosis (BCG) ☐Hepatitis B ☐HIB ☐Flu shot/ Date? ___________

☐Others____________

Childhood Illness: ☐Chicken Pox ☐Mononucleosis ☐Rubella ☐German Measles ☐Diptheria
☐Strep Throat ☐Tuberculosis ☐Scarlet Fever

Medications/Supplements
(Please list all of your medications and supplements that you take regularly below)

Name of Medication/Supplement	Strength	Frequency Taken / Route *(i.e. 2 x per*	How long have you been taking this?

List any surgeries, hospitalizations, imaging (CT, MRI, EEG, EKG, etc), please include dates:

____
____
____
____
____

Tobacco Use History:

- ☐ **Current User** ☐ **Former User**
- ☐ **Never User** ☐ **Other:**

Type of Tobacco Used: ☐**Cigarettes** ☐**Vape** ☐**Cigars/Pipe** ☐**Chew/Snuff**

Start Date:_______________**Quit Date:**_______________**Packs Per Day:**_____________

Do you drink alcohol? ☐Yes ☐No

If "YES", how many of the following per week?: glasses of wine _____ cans of beer ___ shots of liquor____

Do you currently use any of the following recreational or street drugs? *(Please select all that apply)*

☐ Benzodiazepines ☐Cocaine ☐ Crack ☐ Ecstasy

☐ Ketamine ☐ LSD ☐ Marijuana ☐ Meth

☐ Psilocybin ☐ Psychedelics ☐ Other: ________________

Family History

Answer or check those applicable:

	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)						
Health G= good P=						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma, Hay fever, Hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						
Age (at death)						
Cause of death						

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REVIEW OF SYSTEMS

For the following please circle: Y = Yes/Current issue N = No/Never had P = Past problem

MENTAL/EMOTIONAL
Depression Y N P
Mood Swings
Y N P
Anxiety/Nervousness Y N P
Tension Y N P
Memory Problems Y N P
Poor Concentration Y N P
Considered suicide Y N P
Attempted suicide Y N P

SKIN
Rashes Y N P
Itching Y N P
Changes in skin color Y N P
Acne/boils Y N P
Eczema Y N P
Lumps/bumps Y N P
Hair Loss Y N P

HEAD
Headaches Y N P
Head Injury Y N P
Jaw issues or TMJ Y N P

NECK
Lumps in neck Y N P
Swollen Glands
Y N P
Goiter Y N P
Pain or Stiffness in neck Y N P

EYES
Impaired Vision Y N P
Glasses or Contacts Y N P
Eye Pain or strain Y N P
Tearing or dryness Y N P
Double Vision Y N P
Glaucoma Y N P
Cataracts Y N P
Color blindness Y N P

EARS
Impaired hearing Y N P
Ringing in ears Y N P
Earaches Y N P
History of ear infections Y N P

NOSE, THROAT, MOUTH
Stuffy nose Y N P
Frequent Colds Y N P
Frequent sore throats Y N P
Sinusitis Y N P
Hoarseness Y N P
Sore Tongue or lips Y N P
Gum Problems Y N P
Tooth Problems Y N P
Teeth grinding Y N P

RESPIRATORY
Cough Y N P
Excess Sputum Y N P
Coughing up Blood Y N P
Wheezing Y N P
Asthma Y N P
Bronchitis Y N P
Pneumonia Y N P
Pleurisy Y N P
Emphysema Y N P
Pain with Breathing Y N P
Shortness of Breath Y N P
-Lying down? Y N P
Tuberculosis Y N P

CARDIOVASCULAR
High Blood Pressure Y N P
Heart Disease Y N P
Angina Y N P
Chest Pain Y N P
Murmurs Y N P
Rheumatic Fever Y N P
Swelling in ankles Y N P
Palpitations, Fluttering Y N P

PERIPHERAL VASCULAR
Deep Leg Pain Y N P
Cold Hands and Feet Y N P
Varicose Veins Y N P
Thrombophlebitis Y N P

BLOOD
Anemia Y N P
Easy Bleeding or Bruising Y N P
Previous Blood Transfusion Y N P

GASTROINTESTINAL
Trouble Swallowing? Y N P
Change in Thirst Y N P
Change in Appetite Y N P
Nausea Y N P
Vomiting Y N P
Vomiting Blood Y N P
Bowel Movements: Frequency? ______
Is this a change? Y N P
Blood in Stool Y N P
Black stools Y N P
Diarrhea Y N P
Constipation Y N P
Abdominal pain or cramps Y N P
Heartburn Y N P
Belching or passing gas Y N P
Jaundice (yellow skin) Y N P
Liver Disease Y N P
Gall Bladder Disease Y N P
Ulcer Y N P
Hemorrhoids Y N P

URINARY
Pain on Urination Y N P
Increased Frequency Y N P
Frequency at Night Y N P
Inability to hold urine Y N P
Frequent infections Y N P
Kidney Stones Y N P

NEUROLOGIC
Fainting Y N P
Vertigo or Dizziness Y N P
Seizures Y N P
Paralysis Y N P
Muscle Weakness Y N P
Numbness/Tingling Y N P
Loss of Memory Y N P
Loss of Balance Y N P

ENDOCRINE
Hypothyroid Y N P
Heat/Cold Intolerance Y N P
Excessive Thirst Y N P
Excessive Hunger Y N P
Fatigue Y N P
Hyperthyroid Y N P
Diabetes Y N P
-Type 1 or 2? ________
Seasonal depression Y N P

MUSCULOSKELETAL
Joint Pain or Stiffness Y N P
Arthritis Y N P
Broken Bones Y N P
Muscle Spasms Y N P
Weakness Y N P
Sciatica Y N P

IMMUNE
Reactions to vaccines Y N P
Persistent swollen glands Y N P
Slow wound healing Y N P
Chronic fatigue Y N P
Chronic infections Y N P
Night sweats Y N P

BREASTS

Do you perform self-exams? Y N P
Breast Lumps Y N P
Pain or Tenderness? Y N P
Nipple discharge? Y N P

FEMALE REPRODUCTIVE

Are you sexually active? Y N P
Sexual orientation: ____________________
Birth control? Type: ___________________________
Age of first Menses ___________
Age of Last Menses if menopausal:____________
Date of last Pap smear: _____________________________
Abnormal Pap smear? Y N P
If yes, date:_________
Duration of Menses: _________ days
Length of Cycle: _________ days
Regular Cycles Y N P
Bleeding Between Periods Y N P
Painful Menses Y N P
Excessive/Heavy Flow Y N P
PMS? Y N P

If so, what symptoms? __________________________________
____

Menopausal Symptoms Y N P
Vaginal odor Y N P
Vaginal Discharge Y N P
Endometriosis Y N P
Ovarian Cysts Y N P
Gonorrhea Y N P
Chlamydia Y N P
Genital Warts Y N P
Herpes Y N P
Syphilis Y N P
Pain with Intercourse Y N P
Sexual Difficulties Y N P
Difficulty Conceiving Y N P
Number of Pregnancies: __________
Number of Live Births: ___________
Number of Miscarriages:__________
Number of Abortions: _____________

MALE REPRODUCTIVE

Are you sexually active? Y N P
Sexual orientation: ______________
Birth control? Type: _____________
Hernias Y N P
Testicular Masses Y N P
Testicular Pain Y N P
Penile Discharge or Sores Y N P
Gonorrhea Y N P
Chlamydia Y N P
Genital Warts Y N P
Herpes Y N P
Syphilis Y N P
Prostate Disease Y N P
-What Type? _____________________
Impotence Y N P
Premature Ejaculation Y N P