

**New Naturopathic Medicine Patient Registration**

Patient Full Name: _____ DOB: _____

(Last Name)

(First Name)

(Middle Name)

Gender: _____ Pronouns: _____

What would you like me to call you? (Nickname, Chosen name, etc.) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Preferred Contact Phone Number: Cell Home

May we leave confidential voice messages on your phone? Yes No

Occupation: _____ Hours/week working: _____ Retired? _____

Choose one: Married Divorced Widowed Single Partner/Significant Other

PRIMARY CARE PROVIDER:

I wish to establish Primary Care with Dr. McLendon.

I wish to see Dr. McLendon for ancillary/adjunctive care only.

My Primary Care Physician (PCP) is: _____

At (Clinic Name): _____

PREFERRED 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



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 (ex. medication, food, environmental)

Vaccination History: Current on COVID 19 vaccine? _____ Date of last booster: _____

☐ 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 ☐ Diphtheria

☐ 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. 2x per day. oral)	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

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 ☐ Marijuana ☐ Ketamine ☐ Cocaine ☐ Ecstasy ☐ Psilocybin ☐ Psychedelics ☐ LSD ☐ Meth
☐ Crack ☐ Other _____

Family History

Please note any health conditions for the following members of your family. If they are deceased, please note the cause of death and their age at death:

Mother _____

Father _____

Siblings _____

Paternal Grandparents _____

Maternal Grandparents _____

Social History:

Exercise Regularly? Y N #of days/week _____ **Watch TV?** Y N # of hours/week _____

Interests & Hobbies _____

Eat 3 meals/day? Y N **Order out often?** Y N **Do you cook at home?** Y N

Liquids: (# of glasses/day) Water _____ Coffee _____ Soda/Pop _____ Energy drinks _____

Spend time outdoors? Y N **Do you enjoy your work?** Y N

Sleep: How many hours/night? _____ **Time of day when energy is best?** _____ **worst?** _____



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
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/Stiffness in neck Y N P

EYES

Impaired Vision Y N P
Glasses/Contacts Y N P
Tearing or dryness Y N P
Double Vision Y N P
Glaucoma Y N P
Eye Pain or strain 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

Sinusitis Y N P
Hoarseness Y N P
Frequent sore throats Y N P
Stuffy Nose 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
Difficulty Swallowing 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
Swelling in ankles Y N P
Palpitations Y N P

PERIPHERAL

VASCULAR

Deep Leg Pain Y N P
Cold Hands & Feet Y N P
Varicose Veins Y N P
Thrombophlebitis Y N P

BLOOD

Anemia Y N P
Easy Bruising Y N P
Blood Transfusion Y N P

GASTROINTESTINAL

Change in appetite Y N P
Nausea Y N P
Vomiting Y N P
Blood in vomit Y N P
Blood in stool Y N P
Black stools Y N P
Diarrhea Y N P
Constipation Y N P
Abdominal cramps Y N P
Heartburn Y N P
Ulcers Y N P
Belching/Gas Y N P
Liver Disease Y N P
Hemorrhoids Y N P
Gall bladder disease Y N P
Jaundice Y N P

URINARY

Pain with Urination Y N P
Increase in Frequency Y N P
Urinate at night Y N P
Incontinence 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? _____			
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

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' 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: _____



Date: _____

MRN: _____

DOB: _____

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

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

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 **Do Not** approve voicemails when we have questions.

☐ Check box if you **Do Not** want text message reminders.

☐ Check box if you **Do Not** want 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 set pricing on your treatments here. You can use the TOSD for chiropractic, massage, and/or primary care. 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.

We reserve the right, at our sole discretion, to charge a no show/late cancellation fee of \$50.00 per occurrence for missed appointments or appointments canceled less than 24 hours of their scheduled time and date. This will be deducted from any reimbursements made to the patient. If you have a Card on file you authorization us to charge that card.

Patient Name

Date

Patient Signature (Parent Signature if minor)

Parent Name (If Minor)

WHITAKER WELLNESS, LLC



POWELL VALLEY WELLNESS

4253 SE 182nd ave Gresham, OR 97030

(503) 661-5090

CREDIT CARD ON FILE AGREEMENT

Powell Valley Wellness has implemented a new credit card policy. We kindly request our patients for a credit card which may be used later to pay any balance that may be due on your bill. Co-pays are still due at the time of service. The information will be held securely until your insurance has paid their portion of the claim and notified us of any additional amount owed by the patient. At that time, we will notify you that your outstanding balance will be charged to your credit card five (5) days from the date of the notice. You may call our office if you have a question about your balance. This "Card-on-File" program simplifies payment for you and eases the administrative burden on your provider's office. It reduces paperwork and ultimately helps lower the cost of healthcare. If you have any questions about the card-on-file payment method, please do not hesitate to let us know.

This "Card-on-File" can also be used to make payments if you do not want to pay your entire bill at one time. We are happy to charge no interest payments every month until patient's account balance is paid in full. There will be a **minimum** payment amount based on money owed. Our **minimum** payments schedule is:

\$1-\$50 = must be paid in full. Does not qualify for payment plan.

\$51-\$100 = \$20/month payment

\$101-\$500 = \$50/month payment.

Greater than \$500 = \$100/month payment.

By signing below, I authorize Powell Valley Wellness to keep my signature and my credit card information securely on-file in my account. I authorize Powell Valley Wellness to charge my credit card for any outstanding balances when due.

Visa ☐ MasterCard ☐ Discover ☐ American Express ☐

Name on Card (Print): _____

Cardholder Relationship to Patient: _____

Credit Card Number: _____ Exp. Date: ____/____ CVV # (3 digits) _____

Credit Card Holder's Signature: _____ Date: _____



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 each time; this will not be covered by your insurance company.

Patient name

Date

Signature Patient/Guardian