

North Portland Wellness Center – New Patient Info

Welcome to the North Portland Wellness Center. Please print clearly and answer all questions as completely as possible.

Full Name: _____ / _____ / _____ / _____
(Legal Last Name) (Legal First Name) (Middle) (Preferred First Name)

Date of Birth: ___/___/___ Age: _____ Sex/Gender: Female Male Transgendered (circle: FtM/MtF) Other: _____

Address: _____ / _____ / _____ / _____
(Street/PO box) (City) (State) (Zip Code)

Phone #: (_____) _____ (_____) _____ (_____) _____
(Home) (Work) (Cell/Other)

PLEASE CHECK ALL THAT APPLY: I authorize NPWC to leave appointment reminders and detailed medical and insurance messages at any phone number EXCEPT my:
 Home Work Cell/Other
 I need special arrangements (please discuss w/ staff)

Email address: _____

Occupation/Employer: _____ Full-time Part-time Student Retired Unemployed

Are you: Single Married Partnered Divorced Widowed Partner's Name: _____

Emergency Contact: _____ Phone #: (_____) _____ Relationship: _____

How did you hear about our clinic? Please select one of the following, and let us know whom to thank:

- | | |
|--|---|
| <input type="checkbox"/> Live/Work in Neighborhood | <input type="checkbox"/> Insurance Company |
| <input type="checkbox"/> Citysearch | <input type="checkbox"/> Doctor/Clinic: _____ |
| <input type="checkbox"/> Internet Search | <input type="checkbox"/> Event: _____ |
| <input type="checkbox"/> Chinook Book | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Personal Referral: _____ | |

May we send you occasional coupons, discounts, event notices, and/or newsletters via email?
 Y N

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

Patient Signature (or Guardian if Patient is a minor)

Date

Informed Consent to Treatment

MASSAGE THERAPY

The purpose of massage/soft tissue therapy is to decrease pain, tension and tenderness, while increasing blood and lymph flow. Your health concern may be caused by poor body mechanics and/or repetitive stress, in which case, exercises or stretches may be indicated. Massage may cause initial soreness, bruising or lightheadedness, but usually pain relief, increased mobility, and relaxation are experienced.

STEAM/HEAT/HYDROTHERAPY & DETOXIFYING BODY TREATMENTS

Steam, heat, hydrotherapy and other detoxifying body treatments (i.e. bodywraps) are helpful for many conditions, but may not be appropriate for everyone. With steam therapy, there is risk of scalding or serious burns if the patient comes into close proximity of the steam head. Patients should not touch or attempt to move/hold any body part over the steam head, as it releases very hot water. Patients with diabetes, heart disease, multiple sclerosis, abnormally high or low blood pressure, impaired temperature sensation, or who are pregnant or have any other recurrent or persistent medical condition should always consult their primary care physician before utilizing a steam shower or other body treatment. Steam therapy and body treatments can cause people to become tired. Elderly people and young children are more susceptible to exhaustion caused by heat and should avoid lengthy full-body treatments.

Please inform your practitioner of any changes in symptoms, medications, diagnoses by other doctors, and if there is a chance of pregnancy at any time during your care. If you would like additional information on side effects/complications that could result from treatment or product use, please discuss these with your practitioner.

I have read and understand the above statements concerning treatment side effects and risks, and I also understand that there is no guarantee for a specific cure or result. I understand both my rights and responsibilities in this practitioner/patient relationship. I have had the opportunity to read this form and my questions are answered to my satisfaction. I hereby consent to the treatments above.

Patient Name (Please Print)

Relationship to Patient (if not self)

Patient Signature (or Guardian if Patient is a minor)

Date

Office Policies

Please take the time to read, initial, and sign our *Office Policies* to acknowledge your understanding of them. Please note, this is a condensed version of our policies, specifically for non-insurance massage patients. Those wishing to bill insurance or see an acupuncturist, chiropractor, or naturopathic physician will be required to complete our full new patient paperwork packet, which includes the full version of our *Office Policies*.

All payments for services are due and payable at the time of each visit.

Please initial here _____

PLEASE NOTE: There is a \$50.00 fee for each no-show and/or appointment cancellation with less than 24 hours notice. When you schedule an appointment we reserve that time, carefully planned within the context of the week's schedule, exclusively for you. If you miss that appointment or cancel with less than 24 hours notice, it is too late to schedule another patient for your reserved appointment time. This results in a loss of income to both your practitioner and the clinic. In addition, we also incur administrative expenses related to scheduling, staffing, and housing your missed appointment. Therefore, we charge a fifty dollar fee for each no-show and/or appointment cancellation with less than 24 hours notice, regardless of the reason for the missed appointment. This fee cannot be billed to insurance and is fully the patient's responsibility. If you need to cancel or reschedule an appointment, please be sure to notify us at least 24 hours in advance to avoid being charged.

Please initial here _____

Arriving late for an appointment can disrupt your practitioner's schedule and the schedules of all subsequent patients. Therefore, out of respect for our patients and our practitioners, all late patients will have less time for their appointment(s) and will be charged in full. Patients arriving considerably late [ten (10) or more minutes for chiropractic appointments, twenty (20) or more minutes late for all other appointments] *may* have their appointment canceled. These instances are considered late cancellations and are subject to the \$50.00 fee described above.

Please initial here _____

Gift cards/certificates are valid for a specified dollar amount and are not redeemable for cash. They must be presented at the time of service to be redeemed. We are not responsible for lost or stolen gift cards/certificates.

Please initial here _____

For your convenience, we accept the following forms of payment: cash, check, Visa, and MasterCard. It is not our policy to accept out-of-state checks. Please note, there is a \$30 fee for each returned check.

Please initial here _____

As a courtesy to our patients, we ask that you silence your cell phone and other personal devices when entering the center and step outside to take a phone call. We also ask that you use a soft voice while in the building, so as not to disturb other patients receiving treatment.

Please initial here _____

Patient Name (Please Print)

Relationship to Patient (if not self)

Patient Signature (or Guardian if Patient is a minor)

Date

Privacy Practices

As our patient, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which we secure your information confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

In-Office Security

Notes that are taken during appointments are kept in your chart and are secured in our clinic at all times. If patient charts are in public areas, they are kept private with the names covered. Access to this office is limited to practitioners, employees, preceptors, and supervised guests.

Public Interaction

Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc. It is our preference to discuss your health only in the office setting to protect your privacy and to ensure that important information is kept in your chart.

Consultations

North Portland Wellness Center practitioners consult with other healthcare practitioners and clinical/laboratory specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, fax, or email are confidential and names are not used unless necessary and consent is provided from you either verbally or in writing.

Records Released

Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax and are accompanied by a confidential patient information cover sheet, if faxed.

Definitions and Penalties to Comply

Protected health information is any information, whether oral or recorded, in any form or medium that: 1) Is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearinghouse in the normal course of business, and 2) Related to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present or future payment for the provision of healthcare to an individual. This information may reside in any medium: paper, disc, fax, email, and/or digital voice message.

I have read and understand my right to privacy, as stated above, and agree to have the practitioners/staff of North Portland Wellness Center maintain my records confidentially in accordance with the law. I agree to inform the practitioners and/or staff of North Portland Wellness Center if I need any special arrangements pertaining to this issue.

North Portland Wellness Center has the right to update the terms described in this Privacy Practices notice. I may obtain a revised Privacy Practices notice by calling the office and requesting a revised copy be sent in the mail, or by asking for one at my next appointment.

Patient Name (Please Print)

Relationship to Patient (if not self)

Patient Signature (or Guardian if Patient is a minor)

Date

FOR OFFICE USE ONLY: WE ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT OF THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT WERE UNABLE TO DO SO AS DOCUMENTED BELOW:

Date: _____ Reason: _____ Staff Initials: _____

Health History

Name: _____ DOB: _____ Age: _____ Today's Date: _____

GENERAL INFORMATION

Primary reason for seeking massage: _____

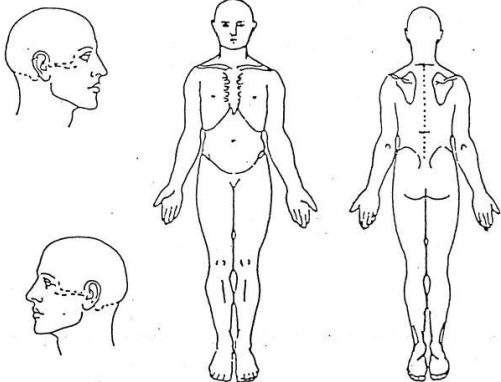
What areas of the body need special focus: _____

Are there any areas you would not like worked on: _____

How often do you receive bodywork? _____ When was your last session? _____

SYMPTOM SURVEY

Please circle any areas where you currently experience **pain**.

	<p>Please list the area of pain and circle level of pain severity (0= no pain, 10= worst pain imaginable)</p> <p>1. Area: _____ 0 1 2 3 4 5 6 7 8 9 10</p> <p>2. Area: _____ 0 1 2 3 4 5 6 7 8 9 10</p> <p>3. Area: _____ 0 1 2 3 4 5 6 7 8 9 10</p>
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DO YOU HAVE ANY OF THE FOLLOWING?:

- | | | |
|---|--|---|
| <input type="checkbox"/> Muscle pain or stiffness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Communicable disease: _____ |
| <input type="checkbox"/> Swollen, painful, stiff joints | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Pregnancy, # of weeks: _____ |
| <input type="checkbox"/> Numbness or tingling | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Tremors, twitches | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Bone pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Body Jewelry |
| <input type="checkbox"/> Loss of strength | <input type="checkbox"/> Hernia | |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> High/Low Blood Pressure | |

Have you been diagnosed with a particular condition (not listed above)? _____

Have you **recently** experienced any hospitalizations, surgeries, or injuries? Yes, please list below No
_____ year: _____ year: _____

CURRENT MEDICATIONS

Are you currently taking any medications? Please list: _____

OTHER

Do you have any questions/concerns or any other information you would like to share about yourself?

Signature _____ Date _____