HILLSBORO NATUROPATHIC CLINIC
245 SE 4TH AVE. STE. E / HILLSBORO, OR 97123
P: 503-844-6667 / F: 503-924-5905
Staff@HNCmed.com

Select Provider: ☐ Victoria Lutskovsky, ND ☐ Valerie Netherland, ND, L.Ac ☐ Kristin Kinnie, MScN, MSW ☐ Sierra Carey, ND

New Patient Adult Intake Packet – Print Clearly

Name (last, first, middle initial): Gender:
Date of Birth:
Address: Street:
City, State, Zip code:
Preferred Phone: **Type:** ☐ **Cell Phone** ☐ **Landline** ☐ **Work**
Are we allowed to leave detailed messages on your voicemail? ☐ Yes ☐ No
Email Address:
Reminder Preference: ☐ Text ☐ Voice Call ☐ Email
Employed? ☐ Yes ☐ No - If yes, occupation? ☐ Full ☐ Part-time
Name of Employer?
Reason for my Visit:

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Other
Spouse/Partner Full Name: Gender:
Preferred Phone: **Type:** ☐ **Cell Phone** ☐ **Landline** ☐ **Work**
Is your spouse your **Primary** Emergency Contact? ☐ Yes ☐ No (Give Information in next section)
Are we allowed to speak to your spouse regarding the following? • Medical Condition – Symptoms, diagnosis, medications, and treatment plan ☐ Yes ☐ No • Appointment Information – Times, dates, and ability to schedule/cancel for you ☐ Yes ☐ No • Mental/Behavioral - Symptoms, diagnosis, medications, and treatment plan ☐ Yes ☐ No • Chemical Dependency - Symptoms, diagnosis, medications, and treatment plan ☐ Yes ☐ No • Billing and Payment information ☐ Yes ☐ No

Emergency Contact Name (if other than spouse/partner):
Relationship to you?
Preferred Phone: Type: ☐ Cell Phone ☐ Landline ☐ Work
Are we allowed to speak to this person regarding the following? • Medical Condition – Symptoms, diagnosis, medications, and treatment plan ☐ Yes ☐ No • Appointment Information – Times, dates, and ability to schedule/cancel for you ☐ Yes ☐ No • Mental/Behavioral - Symptoms, diagnosis, medications, and treatment plan ☐ Yes ☐ No • Chemical Dependency - Symptoms, diagnosis, medications, and treatment plan ☐ Yes ☐ No • Billing and Payment information ☐ Yes ☐ No

{Please ask for an additional form if more people are involved in your health care}

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Insurance Information – Print Clearly

- Verification of benefits does NOT guarantee payment from your insurance. You will be responsible for payment in the event insurance deems service(s) not payable under your plan.

Primary Insurance:
Member ID:
Group Number:
Address to submit claims to:
Phone Number:
Name of Policy Holder:
Policy Holder's Date of Birth:

Secondary Insurance:
Member ID:
Group Number:
Address to submit claims to:
Phone Number:
Name of Policy Holder:
Policy Holder's Date of Birth:

Is your visit related to an accident or injury that is work related? ☐ YES ☐ NO

Is your visit related to an auto accident? ☐ YES ☐ NO

For Women Only:

Are you pregnant or may become pregnant? ☐ YES ☐ NO

Are you currently nursing? ☐ YES ☐ NO

Consent of Treatment: I hereby consent to the administration and performance of all diagnostic procedures and treatment, which, in the judgement of my physician, may be considered necessary or advisable.

I have provided the correct information to Hillsboro Naturopathic Clinic to the best of my ability.

Signature of Patient or Guardian: _____ Date: _____

Patient Name – Printed: _____

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Current Health Concerns

Please describe your main current health problems, including what your opinion as to what could possibly cause this. How long have you had these problems? What treatment have you tried? How did it affect the condition?

Current Medications or Supplements

Name	Dosage	How long have you been taking?

Food Allergies? (Include symptoms you experience)

Medication Allergies? (Include symptoms you experience)

List any past Surgeries:

Have you previously ever seen any of the following?

☐ Naturopathic Physician ☐ Chiropractor ☐ Acupuncturist

☐ Other Alt Care Provider (Pls specify):_____

If you marked any of the above, what was the treatment result?

Are you going through professional counseling? No☐ Yes☐ For how long:

Are you up-to-date on required immunizations? Yes☐ No☐

Please list other diseases in your past:

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Are you a current smoker(tobacco)? No ☐ Yes ☐ Frequency: _____
Did you smoke in the past? No ☐ Yes ☐ Quit Date: _____

Family History

Mother:	**Father:**
Alive? ☐ Deceased? ☐	Alive? ☐ Deceased? ☐
Does/Did this person have any of the following?	Does/Did this person have any of the following?
Asthma Yes ☐ No ☐	Asthma Yes ☐ No ☐
Cancer Yes ☐ No ☐ Type:	Cancer Yes ☐ No ☐ Type:
Heart Problems Yes ☐ No ☐ Type:	Heart Problems Yes ☐ No ☐ Type:
Mental Health Issues Yes ☐ No ☐	Mental Health Issues Yes ☐ No ☐
Osteoporosis Yes ☐ No ☐	Osteoporosis Yes ☐ No ☐
Allergies Yes ☐ No ☐	Allergies Yes ☐ No ☐

Please list known allergies

Other relatives (siblings, grandparents, aunts, uncles, etc) with significant health concerns:

Please sign to show that the information provided is true to the best of your knowledge.

_____

Signature Date

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PAYMENT AND BILLING POLICY

The patient is responsible for paying any and all medical expenses incurred at the clinic. Your health insurance will be billed using information provided by you at the time of service. If you do not have any medical insurance, you will be responsible for the bill at the time of service. Monthly statements will be sent when there is a patient balance and payment is expected within 30 calendar days.

Balances due over 90 days are required to be paid in full. Unpaid balances over 90 days from the date of the first statement sent will be sent to collections.

It is the patient's responsibility to ensure their insurance company will pay for a specific medical procedure. In the event the insurance company denies an insurance claim or portion thereof, the patient is responsible for payment of the claim and account balance, including balances that may be due from an external service provider such as labs or radiology. Additionally, the patient is responsible for payment of the deductible, co-insurance, or copay in accordance with the insurance plan. Please note that if your account is sent to collections, you will be required to pay the balance due in full, ***plus*** the collections service fee prior to being reinstated as a patient and an appointment being made.

If a patient fails to present for a scheduled appointment, arrives so late for the appointment that they are unable to be seen by the provider, or fails to cancel the appointment 24 business hours prior to the time of the appointment, a $75 "Missed Appointment Fee" will be assessed.

If the patient is involved in a motor vehicle or liability accident, the patient is responsible for paying all medical costs. The patient is expected to provide a PIP claim number and insurance adjuster contact information. If there is a lawsuit pending, the patient is expected to provide the clinic with attorney contact information and updates of the status of the lawsuit.

We may use and disclose Protected Health Information to obtain payment for services that we provide to you as well as for other health care operations such as appointment reminders, coordination of care with other providers, and as required for effective care and treatment. Please request the *Release of Medical Records* Form if you wish to have your medical information transferred to or from Hillsboro Naturopathic Clinic.

PATIENT CONTRACTUAL AGREEMENT TO PAY

I hereby agree that I am directly and financially responsible for all medical expenses incurred at Hillsboro Naturopathic Clinic for medical care and treatment. I agree to pay all medical expenses within 30 days of the date I am billed for those expenses unless other arrangements have been made with the Billing Administrator.

I authorize the release of any medical information necessary to secure the payment of benefits. I authorize the use of my PHI on all insurance submissions. I authorize payment of all medical benefits by my insurance company to Hillsboro Naturopathic Clinic.

I further permit a copy of this authorization to be used in place of the original (if applicable.)

This assignment will remain in effect until revoked by me in writing.

_____

Signature Date

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TERMS AND CONDITIONS

- New Patients – Due to the significant amount of time reserved in the schedule for new appointments, a 24-hour business day cancellation is required for all new patient appointments. All new patient appointments that are canceled without a 24-hour notice will be subject to being billed the full cost of the appointment time held ($318.00).

  Initials_____

- No Show / Late Cancel – Please do your best to keep your scheduled appointment. Our policy for missed appointments does not reset yearly, it is ongoing from day one. Each missed or late cancelled (less than 24 business hours) appointment will result in a $75.00 missed appointment fee. For after-hours or weekend cancellations, please leave a message with our answering service.

  Initials_____

- Medicinary and Supplements - All medicinary items are required to be paid for in full at the time of request and will only be held for a maximum of two weeks from the time of request. Failure to obtain requested items will result in re-stocking at the patient's expense.

  Initials_____

- Controlled Substance Policy – Certain controlled substances that are prescribed require specific follow ups and can only be prescribed in certain increments. HNC physicians may require you to have follow up appointments more than once a year to continue to prescribe these medications.
  - Initials_____

- Phone call policy - Physicians encourage patients to call if you have questions after your office visit. It is understood by the physicians and staff that clarifying issues and answering basic questions could assist with the success in your health care. However, phone calls or questions that require a longer time frame (more than 5 minutes), may be billed as a phone consultation. All patients are encouraged to make follow-up office visits; we recommend utilizing this time for multiple questions and for more detailed clarification of information. We encourage our patients to contact us directly during regular business hours.

  Initials_____

- Email Policy ~ Physicians and staff are happy to reply to questions and concerns through email correspondence. If the email correspondence becomes lengthy or excessive, the Hillsboro Naturopathic Clinic physicians and staff reserve the right to request follow-up, either with an office visit or through a Telehealth consultation. Appropriate charges will apply.

  Initials_____

- Payment - for your convenience we accept Cash, Check, Visa, MasterCard, Discover and American Express. Unless previously approved, payment is due in full at time of service.

  Initials_____

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Informed Consent

Any health care is not without its risks or is guaranteed to be successful. Naturopathic care is generally safer than other systems of medicine, but there are potential risks in what we do as well.
By reading and initialing below, you acknowledge your awareness and understanding of such risks.

1. Hillsboro Naturopathic Clinic, the physicians practicing within, and clinical staff do not recommend that you discontinue any other treatment or care provided by any other health care professionals.
2. There is no expressed or implied guarantee of any specific outcome with your treatment provided by the physicians at Hillsboro Naturopathic Clinic or staff. The care provided may or may not be a treatment for a specific disease, and may be preventive in nature, designed to improve your overall health and well-being.
3. Acupuncture treatments may result in a bruise at the site of the needle insertion. Any needle insertion carries a small risk of infection, though we use only single-use, sterile needles to minimize any risk.
4. Personnel of Hillsboro Naturopathic Clinic may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

Digital Communications

Hillsboro Naturopathic Clinic offers the choice to communicate electronically via email, text, and for Telehealth consultations.

What is Telehealth?

Telehealth is the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using information and communication technologies. Telehealth uses health information for diagnosis, therapy, follow-up and/or education. During the Telehealth health service, details of your medical history, examinations, x-rays, and tests may be discussed using interactive video, audio and/or telecommunications technology.

All existing laws regarding privacy and security of your health information and copies of your medical records apply to this Telehealth health service and the audio and video information transmitted.

Hillsboro Naturopathic Clinic will do our best to protect the confidentiality of the patient identification and imaging data.

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Before sending any electronic form of communication to Hillsboro Naturopathic Clinic, please read and understand the following information regarding the risks and conditions of the use of electronic communication.

Transmitting patient information electronically has several risks that should be considered. Some of these risks include, and are not limited to, the following:

- An electronic communication being misaddressed and sent to a non-affiliated recipient.
- Potential backup copies existing even after sender or recipient has deleted their copy or being stored in numerous paper and electronic files.

I understand that by signing below, I have read and fully understand and agree to the terms of the Terms & Conditions, Informed Consent and Digital Communication listed on these forms.

_____

Signature Date

_____

Name of Patient – Printed

_____

Relationship to Patient (if not the patient)

For any questions with billing or to establish a payment plan, please contact our billing company at 503-974-4409. Our reception staff has minimal knowledge of billing and may be unable to answer billing questions.