Patient Intake

Patient Information

Name: First _____Middle: _____ Last: _____

Preferred Name: _____ Gender: M or F Date of Birth: _____/_____/_____

Social Security Number: _____ Home Phone: _(_____)_____

Cell Phone: _(_____)_____ Email Address: _____

Preferred form of communication: (circle) Home Cell Work Email

Can Calypso Natural Clinic staff leave DETAILED messages on your voicemail? **Y or N**

Home Address: _____ City: _____ State: ____ Zip: _____

Employer/School Name: _____

Work/School Phone: _____ Circle: Full Time/ Part Time / Student/ Retired

Employer Address: _____ City: _____ State: ____ Zip: _____

**Preferred Pharmacy: _____ Location: _____

How did you hear about Calypso Natural Clinic? _____

Responsible Party/Guardian Information: (If different then above)

Relationship to Patient: _____ Full Name: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Date of Birth _____/_____/_____ Gender: M or F Social Security Number: _____

Home Phone: _(_____)_____ Cell Phone: _(_____)_____

Primary Insured (If different then above)

Relationship to Patient: _____ Full Name: _____

Date of Birth _____/_____/_____ Social Security Number: _____

Home Phone: _(_____)_____ Cell Phone: _(_____)_____

Home Address: _____ City: _____ State: ____ Zip: _____

Next of Kin / Emergency Contact (If different then above)

Full Name: _____ Relationship to Patient: _____

Address: _____ City: _____State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Patient Signature: _____Date: _____

Calypso Natural Clinic Dr. Amanda Hoffman, ND • Dr. Julie Glass, ND
2191 NW 2nd St Bldg 4 McMinnville, OR 97128 503.472.5500

CALYPSO NATURAL CLINIC

2191 NW 2ND STREET
MCMINNVILLE OR 97128
PHONE: (503) 472-5500

Dr. Amanda Hoffman, ND • Dr. Julie Glass, ND
2191 NW 2nd St Bldg 4 McMinnville OR 97128
Ph (503) 472-5500 Fax (503) 434-1224
Calypsonaturalclinic.com

Others Involved in Health Care

I, _____, give permission to Calypso Natural Clinic to relay information as necessary to the following people listed below.

***Patients 14 years of age and older are required to authorize and sign this form.*

Full Name: _____Relationship to patient: _____

___ Financial information regarding Bills, Insurance, Benefits, etc.

___ Medical treatment, testing, and diagnosis information necessary to serve patient.

Full Name: _____Relationship to patient: _____

___ Financial information regarding Bills, Insurance, Benefits, etc.

___ Medical treatment, testing, and diagnosis information necessary to serve patient.

Patient Signature:_____Date: _____

**(Age 14 years & older) Responsible Party

CALYPSO NATURAL CLINIC
2191 NW 2ND STREET
MCMINNVILLE OR 97128
PHONE: (503) 472-5500

Insurance Benefits Verification

(Be sure to allow 1 hour for this form and bring it *completed* to your first appointment)

Patient Information

Name _____

First Middle Int. Last

Subscriber Information *(if different than above)*

Name _____

First Middle Int. Last

Address_____

Phone_____ Relationship to Patient:_____

Date of Birth ____/____/_____ Social Security Number_____

Employer_____ Employer Phone_____

INSURANCE COMPANY INFORMATION

Name_____

Phone_____

ID #_____ Group #_____

CO-INSURANCE COMPANY INFORMATION Secondary)

Name_____

Phone_____

ID #_____ Group #_____

FORM CONTINUED ON OTHER SIDE

It is your responsibility to be aware of your benefits, including coverage, co-pay, deductible, and maximums. Please call the number listed on the back of your insurance card and fill out the form below.

1. **Name of Representative I am speaking with_____ Date_____**
2. **Beginning Date of Coverage: _____ Ending Date: _____**
3. **Does my insurance cover Naturopathic Doctors? Yes / No**
4. **Is Calypso Natural Clinic a covered Provider under my plan? Yes / No**
5. **Can my Calypso Natural Clinic Doctor be my Primary Care Provider? Yes / No**
6. **Do I need a referral from my primary care physician to see a ND? Yes / No**
7. **What is my co-pay or % covered for:**
    1) **Office Visits_____**
    2) **Lab Work_____**
    3) **Diagnostic Imaging_____**
8. **What is my yearly maximum for Naturopathic office visits? _____**
9. **What is my yearly maximum for lab work / diagnostic imaging?**

    _____
10. **Do I have an annual deductible? Yes / No**

    Amount of deductible met to date_____
11. **Is my deductible based on calendar year? Other? _____**
12. **Are office visits or labs subject to my deductible? _____**

I acknowledge that the above listed coverage information is valid and correct. I understand that benefit verification is not a guarantee of coverage by my insurance company and that I am financially responsible for all services rendered to me by any provider at Calypso Natural Clinic. I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to Calypso Natural Clinic. This authorization will be considered valid unless revoked by me in writing.

Patient Signature _____ Date _____

(or Responsible Party)

Dr. Amanda Hoffman, ND • Dr. Julie Glass, ND

2191 NW 2nd St Bldg 4 McMinnville OR 97128

Ph (503) 472-5500 Fax (503) 434-1224

Calypso Natural Clinic

HIPPA Acknowledgment and Consent for Purposes of Treatment, Payment, and Health Care Operations

I consent to the use or disclosure of my protected health information by my Naturopath at Calypso Natural Clinic for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my health care bills, or to conduct healthcare operations of my Naturopath. I understand that analysis, diagnosis, or treatment of me by my Naturopath may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. My Naturopath is not required to agree to the restrictions I may request. However, if my Naturopath agrees to the restrictions that I request, the restriction is binding to my Naturopath. I have the right to revoke this consent, in writing, at any time, except to the extent that my Naturopath has taken action in reliance on this consent.

My "protected health information" means health information including my demographic information, collected from me, created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or conditions, information that identifies me, or information that provides reasonable basis to believe such information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of my Naturopath and I have read it prior to signing the document. The Notice of Privacy Practices describes the types, uses, and disclosures of my protected health information that will occur in my treatment or payment of my bills. This notice is also posted in the waiting room at 2191 NW 2nd St Bldg 4 McMinnville, OR 97128. The Notice of Privacy Practices also describes my right and duties with respect to my protected health information.

The Naturopath reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of my Naturopath. The requested copy can sent my mail, or at the front desk at the time of my next appointment.

_____ _____

Signature of Patient or Responsible Party Date

Print Name:_____

Dr. Amanda Hoffman, ND • Dr. Julie Glass, ND

2191 NW 2nd St Bldg 4 McMinnville OR 97128 Ph (503) 472-5500

Patient Policies and Billing

Please call 48 hours in advance to cancel your appointment. If you do not call to cancel, you will be charged a cancellation/no show fee of $50. Missed appointments inconvenience other patients. Three missed appointments in a 12-month period will result in your termination from the practice.

Please be prompt for appointments as we take priority in remaining on schedule for the courtesy of all patients. Please call if you are running late, and we will let you know if we can see you or if it will be necessary to reschedule your appointment. If you are late for your appointment by 15 minutes or more, you may be asked to reschedule or to wait until the next available appointment.

Reinstated Care: Unless you are under current care in the office (within the past six months) an examination may be necessary to reinstate proper treatment. Each new injury or concern requires an examination due to the possibility of structural changes or a change in diagnosis.

Prescription Refills: In order to best serve you and give your provider time to consider your prescription requests, we ask that you contact your pharmacy for all medication refills, even if your medication bottle states there are no refills. Our office requires a five-day minimum notice on all medication refill requests. If your prescription is one that must be picked up in our office and hand carried to a pharmacy, you may call the office to make a refill request.

Pain Medications will not be filled without a visit with your provider.

- **Billing:** If you have medical insurance, we will be happy to bill them for you. We are contracted providers for **YCCO, Blue Cross Blue Shield, Aetna, Cigna, Moda/ODS, Pacific Source, United Health, ODS, Providence and Oregon Health Co-Op.** Unfortunately, All **Medicare, Tricare, and Triwest** insurance does not cover Naturopathic office visits. However, lab work and prescriptions under these insurance providers *should* be covered. Always check with your insurance provider to avoid any unexpected charges. We will estimate what your uninsured portion will be and collect the patient portion on the date of service including any unmet deductible. If payment is not received from your insurance we will look to you for payment in full. Your account balance not covered by your insurance company is your responsibility. Please allow 30 days after the time of service for the insurance to respond to your claim. **If your account is turned over to a collection agency, you will incur an additional $100 fee for transfer process.**

- We require your social security number, insurance card, date of birth, and some demographic information for accurate submission of insurance claims.

- You must notify our office of any changes in your insurance coverage. This includes but not limited to loss of coverage, change in carrier, change in coverage, or a change in primary or secondary insurance.

- We have contractual relationships as a "preferred provider" with many carriers, and are bound by our contracts to collect co-pays and co-insurances. We are obligated to notify your carrier if you neglect to pay your "patient responsibility charges."

- Payment due at time of service. Our office accepts Visa, MasterCard, cash and personal checks.

- Litigation; Patients involved in law suits are, as others, responsible for timely payments of charges incurred.

- If your balance is not addressed and is sent to collections a $100 fee will be added to your balance. Clear warnings are sent if this unfortunate event is to occur.

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Billing Primary Insurance: Please take the time to understand your insurance benefits, look at your benefit explanations to

make sure your insurance will cover ND office visits**.** We encourage patients to call their insurance carrier and complete the Insurance Benefits Verification Form while on the phone with the insurance carrier. This will allow us to confirm the amount of your visit that will be covered by insurance, and the amounts you will be responsible for.

Our office can run an insurance benefit quotation for a service fee of $25.00. If you are interested please call the office at 503-472-5500 with your insurance information. **Quotation of benefits is NOT a guarantee of payment. Please understand that you are ultimately responsible for any balances unpaid by your insurance.**

Some insurance companies are not sure if they cover naturopathic services. If there are **any** questions as to whether or not your insurance company will cover naturopathic services, you will need to pay for the visit at the time of service. In these cases we will bill your insurance company after the visit, and if we receive payment we will credit your account and reverse any cash discounts you may have been given. If you prefer to have the insurance reimbursement sent to you directly you must pay in full at our office, and then file your own insurance claim with your insurance company. If you do this you are responsible for all insurance interactions and follow-ups.

Fees: You are subject to a $50 fee for:

- Insurance claims regarding resubmission due to inaccurate or incomplete information provided by patients
- Each and all "no show" appointments or cancellations within 24 hours.
- Returned checks for insufficient funds
- Copies of medical records
- Each re-billing of a past due account
- Past due accounts that are older than 90 days

After-Hours Call: We have a physician on call after hours to handle emergency situations. After-hours calls should be limited to **emergencies only**. Calls for prescription refills, questions about minor illnesses, over-the-counter drug doses, etc., should be made during office hours. After-hours calls will be subject to a **$200 fee.** This fee will be waived if seen within three days of the emergency call.

We are here to help you and pride ourselves in outstanding patient care, please treat the staff with the same courtesy and respect we strive to give to you. We thank you for reviewing these policies.

I have read, agree, and understand the financial and clinic policies of this office and that regardless of insurance; I am ultimately responsible for the balance of my account. By signing this document I agree to any fees that will be applied to my account for failure to follow any policies listed.

_____ _____

Signature of Patient or Responsible Party Date

Calypso Natural Clinic - Dr. Amanda Lynn Hoffman, ND • Dr. Julie Glass, ND

2191 NW 2nd St Bldg 4 McMinnville, OR 97128 • PH 503.472.5500 Fax 503.434.1224

HEALTH HISTORY

Date:__/___/____Patient Name:_____Birth Date:___/____/_____

Additional Physicians_____Phone #:_____

Complaint / Reason for Visit: *Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing that you would like to discuss.*

_____
_____
_____
_____

Medications: *What medications, prescribed or over-the-counter are you currently taking?*

_____
_____
_____
_____
_____
_____

Supplements: *Please list all vitamins, minerals, or other supplements you are currently taking.*

Product Name Date started Amount Frequency

_____
_____
_____
_____

Allergies or Sensitivities: *Please list all Medication, Food, or Environmental reactions*

Allergy/Sensitivity Onset (Child/Adult) Reaction

_____
_____
_____
_____

Blood work: *When was the last date of blood work?*_____

*What tests were performed?*_____

*Were there abnormal results?*_____

PATIENT NAME: DATE OF BIRTH:

Hospitalizations, Surgeries or Major Traumas:

Reason Date Hospital/Physician

_____
_____
_____
_____

Past Conditions/Medical History: *Which of the following have you had or currently have?*

___High Blood Pressure ___Emphysema ___Epilepsy ___Gonorrhea

___Heart Disease ___Heart Arrhythmia ___Ulcers ___Syphilis

___High Cholesterol ___Kidney Stones ___Canker Sores ___Herpes

___Asthma ___Anemia ___Sleep Apnea ___Chlamydia

___Diabetes ___Arthritis ___Eczema ___Venereal Disease

___Thyroid Problems ___Stroke ___Cataracts ___Shingles

___Chronic Infections ___Mononucleosis ___Tonsillitis ___Hepatitis

___Depression ___Seasonal Allergies ___Seizures ___Ear Infections

___Weight Problems ___Cancer: Type_____

Other: _____
_____

Childhood Illnesses: *What childhood illnesses have you had?*

___Measles ___Mumps ___Chicken Pox ___Polio

___Whooping Cough ___Diphtheria ___Rheumatic Fever ___Smallpox

___Scarlet Fever ___Typhoid Fever ___Tuberculosis

Complications (if any): _____

Vaccines: *Check all vaccines that you've received and the approximate year in which your received them. Please list any reactions here:*_____

___Tetanus:_____ ___Diphtheria:_____ ___Pertussis_____

___Hepatitis A:_____ ___Hepatitis B:_____ ___Meningococcal:_____

___Pneumococcal:_____ ___Polio:_____ ___Varicella:_____

___Yearly Influenza:_____ ___MMR:_____ ___ HPV:_____

PATIENT NAME: DATE OF BIRTH:

Please mark if you have had any of the following procedures in the last 5 years:

Procedure	Date	Physician	Procedure	Date	Physician
Colonoscopy			MRI		
Bone Density			CT Scan		
Pap Smear			X-Ray		
Mammogram			EEG		
PSA/Prostate			EKG/ECG		

Family History *Please indicate if you have any family members (biological siblings, parents, grandparents) who have any of the following. STATE Maternal or Paternal Grandparents, aunts uncles, etc.*

___High Blood Pressure: Relation to you:_____
___Heart Disease: Relation to you:_____
___Diabetes: Relation to you:_____
___Stroke: Relation to you:_____
___Osteoporosis: Relation to you:_____
___Bleeding Abnormalities Relation to you:_____
___Anemia: Relation to you:_____
___Asthma: Relation to you:_____
___Cataracts: Relation to you:_____
___Thyroid Problems: Relation to you:_____
___Sickle Cell Disease: Relation to you:_____
___Seizures: Relation to you:_____
___Genetic Condition: Relation to you & type:_____
___Substance Abuse (alcohol, street drugs, prescription drugs)
Relation to you & type:_____
___Female Members with hysterectomies, fibroids, endometriosis etc
Relation to you & type:_____
___Migraines Relation to you:_____
___Mental Illness Relation to you & type:_____
___Autoimmune Conditions Relation to you & type:_____
___Cancer Relation to you & type:_____
___Other: _____

PATIENT NAME: DATE OF BIRTH:

Social History:

Occupation:_____

Do you currently use tobacco? ___yes __no If no, any past use? Y or N Date of last use_____

If yes, what type and how often/much per day?_____

Do you drink alcohol? ___yes ___no If yes, how often/much?_____

If no, any past use? Y or N Date of last use_____

Do you use marijuana/cannabis? ___yes ___no If yes, how often/much?_____

Do you use any illegal, street, or other drugs? ___yes ___no

If yes, what type? How often/much?_____

Sexual Orientation and or Identity:

_____

Religious or Cultural Preferences:

Are there any religious or cultural preferences that you have that might alter or change the type of treatment we may perform? If yes, please clarify:_____

_____

_____

To the best of my knowledge, the above information is correct. I understand that giving inaccurate information may harm me, or my child's medical status. I authorize the health care staff to perform necessary health care services.

Patient's Name (Please Print)_____ Date of birth: ___/___/____

Patient's Signature: _____Date:_____