Milwaukie Natural Medicine, ,LLC6501 SE King Road
Karmen Geller, N.D., L.Ac. Milwaukie, OR 97222
www.milwaukienaturalmedicine.comtel: (503 863-5939 / fax: (503)788-8020

Patient Registration

Name: ______________________ Date: ______________

Preferred Name:____________ Date of Birth: ____________ Gender: ________

Address: ______________________________________

City: ________________ State: ______ Zip: ____________

Phone: ____________(mobile/home) May we leave detailed messages & text reminders? Yes / No

Secondary Phone:______________ (mobile / home)

Email: ________________May we email you with promotions or updates? Yes / No

Emergency Contact: ______________________________

Relationship: ________________ Phone: ______________

Who may we thank for your referral? ______________________

Patient Details

Occupation:________________ Employer:________________

Do you have a Primary Care Provider (PCP)? Yes / No

If Yes, Who is your PCP?______________ Name of clinic/hospital:____________

Race: ☐ American Indian/Alaskan Indian ☐Asian ☐Black/African American

☐Native Hawaiian/Pacific Islander ☐White

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

Smoking Status: ☐Never Smoker ☐Former Smoker ☐Current Smoker

If former smoker, when did you stop smoking?________, how long did you smoke?________

How many packer per week did you smoke?:____________

If current smoker, how many packs per week? ________ , how long have you smoked?________

Insurance Information

Would you like us to bill your insurance? Yes / No If No, skip this section.

** Please hand your insurance card to the receptionist to have it copied for our records, thank you.*

Name of Guarantor:________________ Date of Birth:______________

Relationship to patient:____________ Social Security #:______________

Policy Number:______________ Group Number:______________

Insurance Company:______________

Primary Health Concerns

List what brings you in today, in order of importance to you.

1) ______________ 3) ______________

2) ______________ 4) ______________

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Health History

Height:____________ Weight:____________

Have you had acupuncture before? **Yes / No** Date of last visit:________________

List names and specialties of other healthcare providers you have recently seen: ____________________

____

List medications, vitamins, supplements you currently take and reasons for taking them:

________________________________ ________________________________

________________________________ ________________________________

List any **allergies** to medicine or food sensitivities: ______________________________

Any diagnosed health conditions? ______________________________

List any surgeries, hospitalizations, accidents (include dates): ______________________________

____

Do you have a pacemaker, surgical implants, a history of seizures or fainting? Yes / No

Internal Systems Review

Check all that apply: If YES, please describe...

Headaches	☐	Recent fever or chills	☐
Neck/shoulder tension	☐	Change in appetite	☐
Sinus/congestion issues	☐	Change in weight	☐
Snoring	☐	Unusual fatigue	☐
Cough	☐	Cold extremities	☐
Vision problems	☐	Easy bleed/bruise	☐
Hearing problems	☐	Hair loss/growth	☐
Ear ringing (high/low)	☐	Swelling/edema	☐
Dizzy/vertigo	☐	Body heavy/achy	☐
Memory changes	☐	Run more hot or cold	☐
Sleep difficulties	☐	Sweating (day/night)	☐
Vivid/bad dreams	☐	Skin problems	☐
Seizures	☐	Dryness (where)	☐
Heart palpitations	☐	Urinary complaints	☐
Shortness of breath	☐	Incontinence	☐
Chest pain	☐	Change in sex drive	☐
Abdominal pain	☐	Low back pain	☐
Nausea/vomiting	☐	Knee pain	☐
Heart burn/belching	☐	Numb/tingling (where)	☐
Bloating/gas	☐	Easily irritated/angry	☐
Constipation	☐	Anxiety/panic attacks	☐
Diarrhea	☐	Depression	☐
BM consistency change	☐	Muscle weak/spasm	☐
Blood in stool	☐	Mental confusion	☐
Bad breath	☐	Cancer	☐

Pain Survey

If you are here for general wellness or a non-pain related issues continue to the next section.

Where is your pain / when did it begin? ______________________

What were you doing at the time? ______________________

When is your pain worst/what aggravates it? (i.e. first thing in AM, end of day, sitting, walking, not moving)

____

What makes your pain better? (i.e. heat/ice, immobility, exercise to strengthen, massage, medications)

____

Rate pain 0(least)-10(worst):__________ What percent of time are symptoms present:__________

In the past week, how has your pain interfered with your daily activities (Rate: 0 (no change)-10 (unable to carry on any activity):______________________

Lifestyle

	YES(Rarely)					(a lot)	Additional notes...
Do you have a self-care routine?	☐	1	2	3	4	5	
Do you eat vegetables?	☐	1	2	3	4	5	
Do you exercise?	☐	1	2	3	4	5	
Do you drink water?	☐	1	2	3	4	5	
Do you feel like you are "stressed"?	☐	1	2	3	4	5	
Do you eat fast food/processed foods?	☐	1	2	3	4	5	
Do/did you drink alcohol?	☐	1	2	3	4	5	
Do/did you use recreational drugs?	☐	1	2	3	4	5	

** Please rate how willing you are to make lifestyle changes to accomplish your wellness goals**

unwilling to change at all 1 2 3 4 5 6 7 8 9 10 completely willing

Family Health History

☐ Cancer (type(s):__________________)☐ High Blood Pressure☐ Diabetes ☐Heart disease
☐ Stroke ☐Mental Health Condition☐ Arthritis☐ High Cholesterol ☐Thyroid disorder
☐ Kidney Stones ☐Gall stones☐ Autoimmune Condition Other: ______________________

Women's Health

Date of last period: __________ Days between cycles:______Length of bleeding (days) ___

Menopausal symptoms (hot flashes, night sweats, mood swings, vaginal dryness, etc.):

____

PMS symptoms(nausea/vomiting, headaches, tender breasts, irritability, sadness, change in BM consistency, etc.):

____

Spotting (None / before / after / mid-cycle) How many days ________ Color ______________

Are you pregnant?Yes / No # of pregnancies: __________ # live births: ________

Date of last pelvic exam: ______________Ever abnormal? Yes / No If Yes, when?__________

Mammogram:Yes / No Date of most recent mammogram:_________ Ever abnormal? Yes / No

Patient's Statement of Privacy Rights

As a patient of this practice, you have the right to privacy of your Personal Health Information, and to know that such information shall be properly and securely maintained by this practice, in accordance with our own policy and in compliance with the Health information Accountability and Portability Act of 1996 (HIPAA). HIPAA was enacted to give you, the patient of a health care provider and covered under an health insurance claim, more control over your health information, to set boundaries on the use and release of health records, establish appropriate safeguards that health care providers and others must achieve to protect the privacy of Personal Health Information, and to hold violators accountable, with appropriate penalties for violation of a patient's right to privacy.

AS A PATIENT OF THIS PRACTICE:

1. You are entitled to an individually delivered, written notification of your Privacy Rights at the time of your first visit to this practice's facility. The document you are reading is this notice.
2. You are entitled to see your medical records.
3. You are entitled to receive a copy of your medical records. (Forms are available upon request.) As per allowance by HIPAA the charge will be $0.10 per page.
4. You are entitled to make an amendment to your Patient Health Information within those records.
5. While the provider has a right to deny inclusion of amendments into a patient file, you have the right to disagree with the doctor's refusal of such inclusion of amendment to those records. (Forms are available upon request). If the provider disagrees, he or she shall supply you with written notification of such disagreement.
6. You have the right to specify how access to your health information is restricted from whom.
7. You have the right to indicate the method and/or phone numbers and/or addresses to which telephonic and written communications to you shall be forwarded.
8. No Personal Health Information shall be given out to any entity not related to your treatment and the billing of medical services rendered, without your written authorization.
9. You are entitled to this practice's best efforts to maintain the security of Personal Health Information on your behalf within and outside this office.
10. This practice shall provide Personal Health Information to required parties on the basis of the minimum necessary standard of release (releasing only that information necessary for those parties to provide treatment, reimbursement, or administrative services on your behalf), and so as to maintain the intent of HIPAA in establishing that standard.

PATIENT'S AFFIRMATION OF RECEIPT OF PATIENT'S STATEMENT OF PRIVACY RIGHTS

I hereby acknowledge receipt of this office's Statement of Privacy Rights, provided on my behalf an din accordance with law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

Patient Name	Signature	Date

Milwaukie Natural Medicine, LLC
6501 SE King Road
Milwaukie, OR 97222
(503) 863-5939

FINANCIAL POLICY

PRIVATE PAY PATIENTS

I agree to accept full responsibility to provide payment at the time service is rendered, with applicable discounts applied. On special occasions I may have arrangements made to have my services billed to me. I understand that the terms of this office are to pay the balance within 30 days of the most recent statement (net 30 days). Balances not paid within 30 days may be charged a rebilling fee. If a balance is not paid within 90 days, and my account is sent to a collection agency, I understand that I am responsible for any additional collection and / or attorney fees related to my delinquency.

HEALTH INSURANCE PATIENTS

Insurance billing is a courtesy that this office extends to our patients. I understand that it is to my benefit to confirm my coverage by calling my health insurance customer service representative. Except in the case of In-Network coverage, I agree to accept full responsibility for all amounts not paid by my insurance company and agree to pay the treating provider(s) for all services provided to me which the insurance company denies due to their usual and customary policy or for other reasons. I understand that balances are due net 30 days. It is my responsibility to research possibilities of any further reimbursement from my insurance company for any services or amounts denied.

MOTOR VEHICLE COLLISIONS

It is Oregon state law that in order to have my services paid, by my insurance company I must provide my provider with my insurance company information for billing. If I do not provide this information I agree to the terms set forth under PRIVATE PAY PATIENTS. If my insurance company has not made a payment in 45 days I will assist this office in resolving my account issues. If I have retained an attorney and am expecting settlement I agree to the terms in the DEFERMENT OF PAYMENT AGREEMENT. I understand that it is customary for my insurance company not to cover supplements. Therefore, I agree to pay for these materials at the time of service. In the event my insurance company does pay, my provider will reimburse me. I understand that I may request a receipt from the front desk to use to request reimbursement from my insurance company for the amount of the receipt. I also agree to the terms of net 30 days for any amounts not paid by my insurance company.

ON THE JOB INJURIES

I agree with all state laws in accord with workers' compensation cases. If my insurance company has not made a payment within 45 days I will assist this office in resolving my account issues. I understand that it is customary for my insurance company not to cover supplements. Therefore, I agree to pay for these materials at time of service. I also agree to the terms of net 30 days fro any amounts not paid by my insurance company.

CANCELLATION POLICY: If you are unable to keep an appointment, please give the office 24 hours notice. There is $50 office fee for missed or canceled appointments without 24 hours notice. This fee is your responsibility and cannot be billed to any insurance.

Name	Patient Signature	Date

Milwaukie Natural Medicine, LLC
6501 SE King Road. Milwaukie, OR 97222

Karmen Geller, ND, Lac
Office: (503) 863-5939

Informed Consent for Naturopathic Medical Care, Classical Chinese Medicine & Acupuncture.

I hereby request and consent to examination and treatment with Naturopathic Medicine, Classical Chinese Medicine (CCM) and/or Acupuncture with Dr. Karmen Geller, and/or other licensed doctors of naturopathic medicine or licensed acupuncturists serving as backup for her, hereafter called *allied health care provider*. I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Karmen Geller, and/ or with the allied health care provider providing backup:

(1) my suspected diagnosis(es) or condition(s).
(2) the nature, purpose, goals and potential benefits of the proposed care.
(3) the inherent risks, complications, potential hazards or side effects of treatment or procedure.
(4) the probability or likelihood of success.
(5) reasonable available alternatives to the proposed treatment procedure.
(6) potential consequences if treatment or advice is not followed and/ or nothing is done.

I understand that a Naturopathic evaluation and treatment may include, but are not limited to:

• Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic, well-woman/gynecological, prostate, and neurological exams).
• Common diagnostic procedures (including venipuncture, pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva).
• Soft tissue and osseous manipulation (including, but not limited to therapeutic massage, strain-counter strain, naturopathic/osseous manipulation of the spine and extremities).
• Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections).
• Botanical/ herbal medicines, prescribing of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, tropical creams, pastes, plasters, washes or other forms.
• Homeopathic remedies (highly diluted quantities of naturally occurring substances).
• Hydrotherapy (use of hot and cold water, may include transcutaneous electrode stimulation).
• Counseling (including, but not limited to diet, tobacco cessation, & weight management counselling).
• Over the counter and prescription medications (including only those medications on the Formulary of Oregon Naturopathic Physicians).

I understand that a CCM& Acupuncture treatment may include, but are not limited to:

•Acupuncture/direct moxa: performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or symptoms, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, burning, scarring, pain or discomfort, pneumothorax, and the possible aggravation of symptoms existing prior to acupuncture treatment I understand that I am free to stop acupuncture treatment at any time.
•Chinese Herbs: I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, rashes, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment.

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•Cupping / Acupressure / Tui-Na Massage: I understand that I may also be given cupping / acupressure / tui-na massage as part of my treatment to modify or prevent pain perception, musculoskeletal complaints, and/or to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that cupping, which uses suction over the skin, commonly causes bruise-like marks that can be on the skin for up to one month. I understand that I may stop the treatment if it is too uncomfortable.

•Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy. Please INITIAL the following:

Notice to individuals with bleeding disorders, pace makers, and/ or cancer. For your safety it is vital to alert your provider, Dr. Karmen Geller, of these conditions.

After reading the items below, please initial that you agree to the statements:

_______ I understand that Dr. Karmen Geller is licensed to prescribe controlled substances, but does *NOT* prescribe them for chronic pain management, as they are not appropriate for long-term use.

_______ I understand that Dr. Karmen Geller, will only prescribe medications if she believes that they are in the best interest of myself, the patient.

_______ I understand the US Food and Drug Administration has not approved nutritional, herbal and homeopathic substances; however these have been used widely in Europe, China and the USA for years.

_______ I understand that Dr. Karmen Geller is not a psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies.

I do not expect Dr. Karmen Geller, and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request Dr. Karmen Geller explains therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me.

I have read and understand the above stated policies of Dr. Karmen Geller and will comply with them in all respects. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

I hereby authorize and consent treatment.

Printed Name of Patient	Signature of Patient	Date Signed
Printed Name of Guardian	Signature of Guardian	Date Signed