Milwaukie Natural Medicine, ,LLC
Karmen Geller, N.D., L.Ac.
www.milwaukienaturalmedicine.com

6501 SE King Road
Milwaukie, OR 97222
tel: (503 863-5939 / fax: (503)788-8020

Patient Registration

Name: _____ Date: _____

Preferred Name:_____ Date of Birth: _____

Birth Sex: Male / Female / Intersex - Preferred pronouns: he/him / she/her / they/them

Address: _____City: _____State: _____Zip: _____

Phone: _____(mobile / home) Secondary Phone:_____

May we text appointment reminders? Yes / No - May we leave detailed voicemails on this phone? Yes / No

Email: _____

Emergency Contact/Relationship: _____

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 pack(s) per day did you smoke?:_____

If current smoker, how many packs per day? _____ , how long have you smoked?_____

Do you currently vape nicotine products? Yes / No

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/knees sore	☐
Nausea/vomiting	☐	Muscle weak/spasm	☐
Heart burn/belching	☐	Numb/tingling (where)	☐
Bloating/gas	☐	Easily irritated/angry	☐
Constipation	☐	Anxiety/panic attacks	☐
Diarrhea	☐	Depression	☐
Blood in stool	☐	Change in weight	☐

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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

List Pertinent Medical History for the following family members (such as cancer (what type), diabetes, heart attack, hypertension, stroke):

- Mother:_____ Maternal Grandparents: _____
- Father: _____ Paternal Grandparents:_____
- Siblings: _____ 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

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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

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NATUROPATHIC MEDICINE AND CLASSICAL CHINESE MEDICINE CONSENT TO ESTABLISH CARE AND TREAT

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 Milwaukie Natural Medicine. I understand that patient care is directed by a licensed health care provider. I consent to services rendered to me under the instructions of these professionals.

I understand I have the right to ask questions and discuss to my satisfaction with the above-mentioned providers and/or students:

- 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, lung function testing, and referrals for external diagnostic procedures).
- 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 Parental Injection consent below).
- 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 lifestyle and diet change, 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).
- Classical Chinese medicine procedures including, but not limited to acupuncture, moxibustion, cupping, electroacupuncture, herbology, and massage. Possible risks and complications associated with these procedures may include:
    - Slight burns ▪ Fainting ▪ Bleeding ▪ Nausea ▪ Scarring ▪ Tingling/soreness near needling sites ▪ Infections and blisters ▪ Bruising that may last a few days

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I have read and understand the above stated policies of Milwaukie Natura Medicine 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

Patient Informed Consent Form for Use of Freed, an AI-Powered Medical Documentation Tool

Freed is a HIPPA compliant application powered by an AI to assists healthcare professionals in data collection and generating clinical notes, which in turn aids in patient care. The application can process information provided in various forms, such as text, audio, and live patient conversations and generate notes for your provider.

Purpose of Use:

- The use of Freed is intended to improve the efficiency and accuracy of medical documentation, thereby freeing more time for your healthcare provider to focus on your care during your visit.

Data Processing, Confidentiality, and Security:

- While Freed assists in the process of note-taking and generation, it's important to note that the system may process sensitive health information provided during your consultation. The information processed by Freed is strictly used for the purpose of your ongoing medical care and is subject to strict data privacy regulations to ensure your information remains confidential. The only patient-identifying information listed on Freed is your first name. All recordings are deleted as soon as the note is generated.

Risks:

- While Freed is designed to improve the efficiency of your medical care, there are potential risks associated with its use. These include, but are not limited to, inadvertent errors in transcription or interpretation of your health information, and potential, though highly unlikely, breaches of data security. Please be assured that Freed does not have access to any patient-identifying information beyond your first name (Freed does not have access to your DOB, address, telephone, insurance info, ect).

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