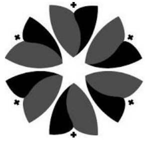


**Salem Naturopathic Clinic, P.C.**
1305 Broadway Street NE • Salem, OR 97301 • ph. 503 364-1441 • fax 503 364-9924

Dr. Donald McBride, N.D.

## Patient Information

| First Name | Middle name | Last Name | Preferred Name |
|---|---|---|---|
| Date of Birth | Social Security No. | Preferred pharmacy | Gender / Marital Satus |
| Employer | | Occupation | |
| Home Address | City | State | Zip Code |
| Mobile Phone | Home Phone | Work Phone | |
| email | | Would you like to receive appointment reminders by text and email? If yes, who is your cell carrier? | |

## Emergency Contact Information

| Name | Phone | Relationship |
|---|---|---|
| May we discuss your billing and/or treatment with the above named? | | |

**Do you have insurance coverage? Yes ❘ No ❘**

## Insurance Information

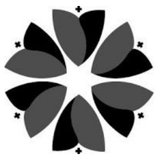
The information below will assist us in determining if some of the expenses are reimbursable by your HMO or insurance carrier.
We cannot guarantee insurance coverage by your insurance carrier.
**Please give your insurance card to our receptionist to be copied.**

| **Primary Insurance Carrier** | ID # | Group # | Social Security No. |
|---|---|---|---|
| Name of Insured/Subscriber | Relationship to Patient | Date of Birth | Gender M F |
| **Secondary Insurance Carrier (if applicable)** | ID # | Group # | Social Security No. |
| Name of Insured | Relationship to Patient | Date of Birth | Gender M F |

| Initial | Authorization and Release |
|---|---|
| | I certify the above information is true and correct to the best of my knowledge. I certify that I (or my dependent) have insurance coverage and assign directly to **Salem Naturopathic Clinic, P.C.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand and agree that I am ultimately responsible for payment – and that at this time services rendered ***may not*** be covered by my insurance. I understand that I am financially responsible for all charges whether or not paid by insurance. |
| | I authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that billing is done by a third-party and that I may contact them with questions regarding my account. |

Patient / Responsible Party Signature ______________________ Relationship ______________ Date ______________

Revised 02/2020



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Marital Status: ________________________

Spouse's Name:________________________
*If Applicable*

Are Vaccines Current? Y N Declined

Last Physical Exam:_____________________
*Or Last Well Child Visit*

Height:____________Weight:____________

Gender: Male Female

<u>If Male</u>, Last Prostate Exam/PSA Evaluation: ____________________________________________

<u>If Female</u>, Last Pap Test: ____________________

Last Breast Exam:______________________

Last Mammogram: ________________

Do you do self exams? Y N

Last Chest X-Ray:___________________________

Last Blood Tests: _______________________

Last Eye Exam: ___________________________

Last Dental Visit: _______________________

Any other diagnostic tests in the last 3 years? If so, what test and when?

_____________________________________________________________________________________

_____________________________________________________________________________________

<u>For Adults</u>, when was your last

Pneumonia Vaccine: _____________ Tetanus Booster:_____________ Flu Vaccine:_____________

Please list ***all*** <u>medications, vitamins, herbs, hormones and other prescriptions</u> you currently take:

_________________________ ___________________________ _________________________

_________________________ ___________________________ _________________________

_________________________ ___________________________ _________________________

_________________________ ___________________________ _________________________

Please list any past surgeries / hospitalizations, including approximate date:

________________________________________ ________________________________________

________________________________________ ________________________________________

Do you have a family history of any of the following diseases: (check all that apply)

| | Sibling | Mother | Father | Maternal Grandfather | Maternal Grandmother | Paternal Grandfather | Paternal Grandmother |
|---|---|---|---|---|---|---|---|
| Diabetes | | | | | | | |
| Cancer | | | | | | | |
| Heart Disease | | | | | | | |
| Stroke | | | | | | | |
| Other | | | | | | | |

Date of Last Medical Care:___________________Who Treated You?_______________________________

Primary Care Medical Provider:______________________________________________________________

Please list all your known allergies – drug, food, insect/animal, etc.:

_________________________________________________________________________________________

_________________________________________________________________________________________

I have questions about:

Diet Exercise Vaccinations Current Medications

Prevention of__________________________________ Other____________________________________

What are your major health complaints, listing the most important first?

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

What treatments have you tried for the above complaints?

_________________________________________________________________________________________

_________________________________________________________________________________________

Hobbies:_________________________________________________________________________________

What type of exercise do you participate in?_________________________________________________

Is there anything else you think would be helpful for us to know in assessing your care?

_________________________________________________________________________________________

**Rate the following as: 1=three or four times yearly, 2=monthly, 3=once a week, 4=daily**
**Please add comments to clarify the symptoms listed, leave blank any that do not apply**

**Head:**
1.______ Headaches
2.______ Dry scalp
3.______ Acne
4.______ Dizzy
Other: ________________________

**Gastrointestinal:**
1.______ 'Heartburn'
2.______ Stomach aches
3.______ Gas/bloating
4.______ Fatty meals bother
5.______ Constipation
6.______ Diarrhea
7.______ Blood/mucus in stool
8.______ Vomiting
9.______ Hemorrhoids
Bowel movements:
______ Daily
______ Other
Other:________________________

**Musculo-skeletal:**
1.______ Joint pains
2.______ Back pain
3.______ Neck pain
4.______ Muscle aches
5.______ Bruising
6.______ Sprains
7.______ Joint stiffness
8.______ Arthritis
Other:________________________

**Diet (on an average day):**
Breakfast:
________________________________
________________________________
Lunch:
________________________________
________________________________
Snack:
________________________________
________________________________
Dinner:
________________________________
________________________________
Liquids:

If you smoke, how much?
________________________________
If you drink alcohol, how much?
________________________________
Other:_________________________
________________________________

**Chest:**
1.______Shortness of breath
2.______ Heart pounds
3.______ Heart 'flutter'
4.______ Asthma
5.______ Chest pains
6.______ Wheezing
7.______ Coughing
Other:____________________________

**Urinary Tract:**
1.______ Bladder infections
2.______ Kidney infections
3.______ Burning during/after urination
4.______ Frequent urination
5.______ Blood in urine
Other:______________________________

**Energy (check if it applies):**
1.______ Sleep soundly
2.______ Wake rested
3.______ Feel energetic in the morning
4.______ Slow starter
5.______ Afternoon slump/tiredness
6.______ Tired all day
7.______ Low energy even with sleep
8.______ Feel restless when trying to sleep
9.______ Wake up easily at night
Other: ______________________________

**Male Only:**
1.______ Frequent urination (day, night)
2.______ Incomplete urination
3.______ Discharge from urethra
4.______ Trouble initiating urination
5.______ Hernias
6.______ Decrease in sex drive
7.______ Erectile difficulty
8.______ Rectal burning/itch
Other:______________________________

**Eye/Ear/Nose/Throat:**
1.______ Vision blurry
2.______ Dry eyes
3.______ Dark circles under eyes
4.______ Ear wax builds up
5.______ Ear aches
6.______ Hearing loss
7.______ Ringing in ears
8.______ Sinus pain/infection
9.______ Nose/sinuses dry
10._____ Nose runs
11._____ Seasonal allergies
12._____ Voice hoarse
13._____ Sore throat
14._____ Post nasal drip
15._____ Nose bleeds
Other:______________________

**Neuro-Endocrine:**
1.______ 'Panic' / anxiety attacks
2.______ Irritability
3.______ Feel bad when not eating regularly
4.______ Weight gain
5.______ Weight loss
6.______ Mood swings
7.______ Snack often
8.______ Increased thirst
9.______ Insomnia
10._____ Increased appetite
11._____ Decreased appetite
12._____ Heart races
13._____ Easy fatigue
14._____ Feel down/depressed
15._____ Poor memory

**Female Only:**
1.______ PMS symptoms
Duration:__________________
2.______ Menses painful
3.______ Menses change
*(duration, regularity, flow, pain)*
Average Cycle length: _____ days
4.______ Absent menses
Menopause began: _________________
5.______ Decrease in sex drive
6.______ Vaginal discharge
7.______ Yeast infections
8.______ Hot flashes
9.______ Acne at/before menses
10._____ Pain in breasts
With cycle or constant?________________
11._____ Hair growth on face
12._____ Difficulty in:
Conception or Carrying to Term?
13._____ Hernias
14. Number of pregnancies_____________
15. Number of births__________________
Other:___________________

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# Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality care. We are sure you understand that payment for this service is your responsibility. This policy outlines your financial responsibilities related to payment for professional services. Please read it and ask us any questions you may have. When completed, please sign in the space provided. A copy will be provided to you upon request.

**Insurance.** We can bill most insurance plans, however are not a contracted Medicare provider and we may not be in-network with your insurance company. We will bill your primary insurance and, if applicable, a secondary insurance. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

1. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We will obtain a copy of your photo I.D. and valid insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the charges. If you do not have your insurance card with you, payment in full for each visit is required until we can verify your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may not be covered. You must pay for these services in full at the time of visit or after your insurance has denied them.

4. **Claims submission.** We will submit your claims to assist with payment. Please be aware that your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

5. **Claim Payment.** If your insurance company does not pay within a reasonable time period of 90 days, you may be billed. If we later receive payment from your insurer, we will refund any overpayment to you.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. Failure to provide new insurance information at the time of your appointment may result in payment responsibility to fall to you.

**Non-Insurance/Self-Pay.** If you do not have insurance or have insurance that does not provide payment for our services, you will be considered a self-pay patient and payment in full is expected at each visit.

**Lab Services.** We can obtain and process a specimen here in our office and send it to our third-party laboratory for analysis for your convenience. If you wish to go elsewhere, we can provide you with a lab order to take to a lab better covered by your insurance or more convenient for you.

**Supplements**. Many supplements are available for purchase at Salem Naturopathic Clinic. We do not bill insurance for supplements. Payment for supplements must be made in full at the time of purchase.

**Non-Sufficient Funds.** If you present a check for payment to Salem Naturopathic Clinic and it is not honored by your bank, a $25 Non-Sufficient Funds charge will be added to your account per occurrence.

**Medical Record Copies.** Salem Naturopathic Clinic charges $25 per request to copy your medical records for you. (This fee does not apply to records requests from other providers). You must complete a Medical Records Request Form and pay the copying fee prior to our releasing records to you.

**Cancellation and Missed Appointment Policy.** As a courtesy, we request that you provide us with 24 hours notice if you must cancel or reschedule an appointment. After the second consecutive cancelled or rescheduled appointment with less than 24 hours notice, a $50 late cancellation fee will be added to your account. Payment of the late cancellation fee must be made prior to scheduling your next visit. After a third missed appointment without advanced notice, you may be dismissed from the practice. Please help us to serve you better by keeping your regularly scheduled appointment or providing at least 24 hours notice in the event you must cancel or reschedule.

**Nonpayment.** If you are a self-pay patient and your account is over 90 days past due OR if you are are billing insurance and your account is over 120 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated with our billing service. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency and you and your immediate family members will be discharged from this practice. In addition, if your bill is dismissed by a court as part of your bankruptcy, you and your immediate family members will be discharged from this practice. If you are dismissed from this practice, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician(s) will only be able to treat you on an emergency basis.

Thank you for understanding our Payment Policy. Please let us know if you have any questions.

**I have read and understand the Payment Policy and agree to abide by its guidelines:**

| ______________________________________ | ____________________ |
|---|---|
| Signature of Patient or Legal Guardian | Date |
| ______________________________________ | ____________________ |
| Print Patient Name & Legal Guardian (if applicable) | Relationship to Patient |

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I have been given the opportunity to read and review a copy of Salem Naturopathic Clinic, P.C.'s Privacy Practices. I have had all questions regarding these procedures answered to my satisfaction. These policies are in accordance with the most current HIPAA guidelines in my State.

Signed by:

_______________________________________ _____________________
Signature of Patient or Legal Guardian Relationship to Patient

_______________________________________ _____________________
Print Patient's Name Date

_______________________________________
Print Name of Legal Guardian (if applicable)

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# Informed Consent to Naturopathic Medical Care

I hereby request and consent to the performance of evaluation and management services as well as other procedures by my doctor at the Salem Naturopathic Clinic, PC. I understand that I have the right to ask questions and discuss to my satisfaction with Dr. _________ the nature and purpose of naturopathic medical evaluation and treatment and other procedures which my naturopathic physician may administer.

I understand and am informed that:

1. Naturopathic Medicine is the science, philosophy and art of identifying and treating diseases, dysfunctions, disorders and imbalances of normal human physiologic function. There has been no promise implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic.

2. As with any practice of medicine, it is not an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

3. I understand that my physician may administer manual therapy using his/her hands. I understand that my physician may use manipulation of joints, tendons, muscles and connective tissue in the body to restore motion / mobility. He or she will use his hands or a mechanical device upon my body to adjust a joint which may cause an audible "pop" or "click."

4. It is not reasonable to expect my physician to be able to anticipate, or explain, all possible risks and complications of a given procedure on any particular visit and I wish to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest.

5. An undesirable result, or side effect, does not necessarily indicate an error in judgment or an improper treatment. I agree to communicate any such information to my physician in a timely manner so that changes in my treatment plan, if any, can be made.

6. As with any healthcare procedure, there are certain complications which may arise during any given medical procedure. Those complications from manipulation include sprains/strains, dislocations, fractures, disc injuries, or cerebral-vascular accidents. Complications from injections may include pain at site of injection/infusion, allergy to injectant resulting in anaphylaxis, which may be fatal; light-headedness and weakness after injection. These complications are extremely rare occurrences.

I have read the above consent, or had it read to me, have had the opportunity to ask questions and receive answers, am comfortable with the information provided and consent to naturopathic medical evaluation, treatment and management on that basis.

| | |
|---|---|
| ______________________________ | ______________ |
| Patient's Name (Printed) | Date |
| ______________________________ | ______________ |
| Patient's Signature | Relationship to Patient |

Revised 02/2020