NUNM Health Centers – Community Clinics Registration
PLEASE WRITE LEGIBLY

Patient Name: _____ DOB: _____
Last Name First Name Middle Name

What is your preferred first name? (Nickname, Chosen name, etc)

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell phone: _____ Email address: _____

Preferred Contact Phone Number: □ Cell □ Home □ Work SSN: _____

Is it ok if we email you with instructions to sign up for MyChart? □ Yes □ No

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The information you provide helps us to serve you and other members of the community and assists us to help you reach your health goals. Please answer all questions.

What is your birth sex? □ Male □ Female Other (specify) _____
What gender do you identify as? □ Male □ Female Other (specify) _____
What is your preferred pronoun? □ He □ She Other (specify) _____

Interpreter needed? □ Yes □ No Primary Language: _____

Homeless Status? □ Not Homeless □ Homeless □ At Risk □ Transitional Housing □ Living in Shelter

Seasonal or Migrant Worker? □ Seasonal □ Migrant □ Neither

Ethnic Group (Select One): □ Hispanic □ Non-Hispanic Are you a US Veteran? □ Yes □ No Race

(Select all that apply): □ Asian □ Black □ White □ Alaskan Native □ Pacific Islander □ American Indian

Occupation: _____ Hours per Week: _____

Employer: _____ Address: _____

City: _____ State: _____ Phone: _____

Employment Status (Check one): □ Full Time □ Not Employed □ Part Time □ Retired □ Seasonal

□ Self-Employed □ Student (Full Time) □ Student (Part Time) □ NUNM Student

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Primary Care Provider (PCP) Information (Please select one of the following):

□ I wish to establish Primary Care with NUNM Health Centers _____.

□ I see NUNM for ancillary/adjunctive care only.

My Primary Care Physician (PCP) is: _____

At (Clinic Name): _____

□ I do not have a Primary Care Physician and do not wish to establish Primary Care with NUNM at this time.

PATIENT REGISTRATION FORM CONTINUED

Emergency Contact Name: _____

Relationship: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Legal Guardian? □ Yes □ No

Guarantor (Person who is financially responsible for the account):

Name: _____ Relationship to the patient: _____

Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Gender: □ M □ F DOB: _____

Guarantor Primary Language: _____

The NUNM Health Centers Billing Department requires that ***all*** insurance coverage be pre-verified (7 business days) before we are able to bill for you. If this process has not been completed ahead of your appointment time, we will provide documentation of your visit to submit to your insurance company. You will be given any applicable discount for your office visit.

Please provide your insurance information below:

Insurance Company: _____

Claims Address: _____

Subscriber Name (if other than patient): _____ DOB: _____

Member ID #_____ Group # _____ Subscriber ID #_____

****Please be prepared to present your insurance card at check-in at each visit****

****Although NUNM is not contracted with Medicare, it is our policy to collect all coverage information****

Do you have Medicare? □ Yes □ No If "yes", is it your primary insurance? □ Yes □ No

Medicare Plan (check all that apply): □ Part A □ Part B □ Advantage (Part C)

Subscriber ID #_____ Effective Date (if known): _____

I authorize the following individual(s) to arrange appointments at NUNM Health Centers on my behalf: (OPTIONAL)

Name: _____ Name: _____

DOB: _____ DOB: _____

Relationship to Patient: _____ Relationship to Patient: _____

I certify the above information is true and correct to the best of my knowledge.

_____ _____

Patient Signature **Date**

Consent for Treatment

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 at the National College of Natural Medicine (NUNM) Clinic or community clinics. I understand that patient care is directed by licensed health care providers who are employees of NUNM. I consent to services rendered and provided to me under the instructions of these professionals, as well as volunteer staff physicians who may be associated for the purpose of consulting.

I recognize that NUNM is a teaching institution. I agree that persons who are students and resident physicians may participate in my care as part of the educational programs of the institution.

I have fully read and understand the above agreements and authorizations.

To attest to my consent, I hereby affix my signature to this authorization for treatment.

_____	_____	_____	_____
Date	Patient's Name (Print)	Patient's Signature	Date of Birth

Consent to treatment of a Minor Child:

I, _____, being the parent/legal guardian/personal representative of _____have read and fully understand the above informed consent and hereby grant permission for my child to receive treatment at NUNM Health Centers or community clinics.

Statement of Financial Responsibility

I understand and agree to the following general responsibilities:

- ☐ Financial options are extended to me based on the information I have provided.
- ☐ I am responsible as the patient or patient's guarantor for full payment of services rendered at the time of service (unless payment arrangements have been made), including Medicinary, lab work and tests, and physician ordered add-on lab work and tests.
- ☐ I am responsible for providing all accurate and thorough documentation required to support any discounts I am receiving.
- ☐ I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the NUNM Community Clinic to release information necessary to secure payment.

I have fully read and understand the above agreements and authorizations.

_____ _____

Sign Patient (18 years or older) **Date**

_____

Print Name Patient (18 years or older)

_____ _____

Sign Parent, Guardian, Responsible Party **Date**

_____

Print Name Parent, Guardian, Responsible Party

HIPAA Notice of Privacy Practices and Consent

I hereby consent to the use and disclosure of my Protected Health Information by National College of Natural Medicine (NUNM), aka NUNM Health Centers, for the purposes of treatment, payment and healthcare operations, or as otherwise required by law.

- ☐ NUNM has posted their Notice of Privacy Practices which provides more detailed information about the usage and disclosure of my Protected Health Information. I have a right to review the Notice prior to signing this consent and to receive a printed copy of the Notice.
- ☐ I have the right to request restrictions to the usage and disclosure of my Protected Health Information.
- ☐ I have the right to request an alternative to the standard method of communication of my Protected Health Information.
- ☐ I have the right to revoke this consent, in writing, at any time. Revocations will be honored as of the date they are received by the NUNM Health Centers at the following address: 3025 SW Corbett Avenue, Portland, Oregon 97201
- ☐ I understand that while NUNM may honor these requests, they are not required by law to do so.
- ☐ NUNM is part of an organized health care arrangement including participants in the Oregon Community Health Information Network (OCHIN) which utilizes the *Care Everywhere* system. A current list of OCHIN participants is available at http://www.community-health.org/partners.html. As a business associate of NUNM Health Centers OCHIN supplies information technology and related services to NUNM Health Centers and community clinics and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by NUNM Health Centers and community clinics with other OCHIN and *Care Everywhere* participants only when necessary for health care operations purposes of the organized health care arrangement.
- ☐ I am aware that NUNM reserves the right to change the terms of their Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all Protected Health Information that they maintain. In the event of amendments, NUNM will make available a revised Notice of Privacy Practice for my review.

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_____ _____

Patient (18 years or older) Date

_____ _____

Parent, Guardian, Responsible Party Date