



NUNM Health Centers – Beaverton Registration
PLEASE WRITE LEGIBLY

Patient Name: Last Name First Name Middle Name DOB:

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

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

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

I wish to establish Primary Care with NUNM Health Centers – Beaverton.

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 University of Natural Medicine (NUNM) Health Centers - Beaverton. 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 – Beaverton.

## **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 Beaverton 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 University of Natural Medicine (NUNM), aka NUNM Health Centers – Beaverton, 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 – Beaverton at the following address: 11975 SW 2<sup>nd</sup> St. Suite 110 Beaverton, OR 97005.
- 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 – Beaverton OCHIN supplies information technology and related services to NUNM Clinic 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 – Beaverton 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.

\_\_\_\_\_  
Patient (18 years or older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent, Guardian, Responsible Party

\_\_\_\_\_  
Date